Gloucestershire Safeguarding Children Board

OVERVIEW REPORT

in respect of the

SERIOUS CASE REVIEW

for

Liam

FINAL 20200330

Independent Overview Author – Beverley Czyz
April 2020 – V.3

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Executive Summary

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i) This review concerns the sudden unexpected death of Liam aged one month, both he and his half sibling (Logan) were also subject to a child protection plan. Their mother's first child (Emma) had also been subject to a child protection plan for neglect and emotional harm and had subsequently been made the subject of a Special Guardianship Order in 2015.

Individual Agency Recommendations

ii) The individual agencies who participated in this Serious Case Review have each identified learning for their respective agencies through the production of their Individual Management Review reports and the wider Serious Case Review process. Each agency has implemented recommendations for improvement through a single agency action plan agreed by their agency's Senior Management. These actions will be monitored within individual agencies who will provide assurance to the GSCE that they are producing the necessary improvements identified and demonstrating impact. Specified questions posed in the Terms of Reference, attached as Appendix A were addressed within Individual Management Review reports and taken into consideration.

Overview Report submission to the LSCB

iii) This serious case review is submitted to the Local Safeguarding Childrens Board for their information and consideration of promulgating the lessons to be learnt from the suggested enclosed findings and recommendations.

Independent Overview Author

iv) Working Together to Safeguarding Children (2015) states that '*the LSCB must appoint ...suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance*' and that '*the lead reviewer should be independent of the LSCB and the organisations involved in the case*'. I confirm that these requirements are met.

v) I am indebted to those individuals who supported the review process and contributed to the learning. I was fortunate to meet with Liam's mother and maternal grandmother as well as Emma's Special Guardians as part of this review. I am grateful to the practitioners who attended the practitioner learning event who provided valuable insight into the services provided and their consideration of what works or could be improved in working with families in similar circumstances.

vi) It is hoped that the learning from this review will strengthen services to expectant and new parents, especially those who are additionally challenged by personal, social and economic difficulties. The report has been commissioned by and written for the GSCB. In reflecting the importance of accountability to the wider public, the report will be published on the GSCE website. As such, the details of the child and their family, and the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

vii) The following learning points and recommendations were made:

Learning point one - Recognition and response to neglect

The multi-agency partnership response to neglect continues to need to be strengthened to ensure practitioners are competent and confident in working with all aspects and types of neglect including assessment of parenting capacity, motivation to change and sustainability of any improvements once services withdraw. Practitioners need to be equipped to recognise possible feigned compliance and to address this in assessment and plans.

Recommendation 1

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- The GSCE needs to assure itself that the planned refocus on the GSCB Neglect Strategy, procedures, single agency training and multi-agency training programme results in demonstrable improved outcomes for children living in neglectful circumstances.

Learning point two – The importance of robust and timely pre-birth assessment

This review has highlighted the importance of pre-birth planning and assessment in ensuring early understanding of possible risks as well as the level of support required by their parents as their carers to ensuring the future safety and well-being of the unborn child.

Recommendation 2

- The GCSE should consider how the partnership can support the improvement needed in practice and assure itself that all aspects of pre-birth assessment and planning meet practice expectations and demonstrating improved decision making and outcomes for babies.

Learning Point three – Recording practice and information management

Record keeping was not of sufficient content or quality to know what was happening for the family, what risks were identified and the rationale for any decisions or actions to be taken. Due to the 'carry forward' from previous documents and missing information records were not always clear regarding the work to be undertaken and whether the desired outcomes of assessment and plans had been achieved. It is vital that agencies scrutinise themselves regarding the deficits found in record and information management.

Recommendation 3

- Individual agencies should ensure record keeping and information management systems within their organisation are robust and routinely implemented and that any deficit in the information is addressed by practitioners with appropriate management oversight.

Recommendation 4

- Where information is missing and reliant on another practitioner or agency to provide it this should be addressed by practitioners through the GCSE Escalation Policy (2019)

Recommendation 5

- The GSCE should assure themselves as to the impact on recording and information management practice drawing on the existing recommendations from three recent Serious Case Reviews.

Learning point four – Escalation and resolving professional disputes

More needs to be done to promote the role of escalation in partnership working together with respect and mutual understanding of others' roles and responsibilities and understanding of the limitations in practice. There should be a focus on restorative practice principles that foster and enhance partnership working and a culture where respectful professional challenge is productive and welcomed.

Recommendation 6

- The GCSE should seek assurance that the systemic findings in learning point four are being addressed and consider and implement appropriate models and problem-solving approaches to address them.

Recommendation 7

- The GCSE should seek assurance regarding the individual agency uptake and evidence of impact of its multi-agency training around resolving professional disputes and escalation.

Learning point five – Professional Over Optimism

This review found that there was evidence of professional over optimism that appears to be a feature of general practice particularly when working with neglect, poor mental health and substance misuse.

Recommendation 8

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- The GCSE should seek assurance that the systemic findings in learning point five are being addressed and practitioners are equipped to work with them in a competent and confident manner.

Learning Point six – Substance use and maternal mental health

This review found that despite the long history of maternal substance misuse and fluctuating maternal mental health there was a lack of professional recognition and response.

Recommendation 9

- Practitioners across agencies should be equipped to robustly assess the significance of substance misuse and poor maternal mental health and its impact on parenting capability and put in place an appropriate plan of support and intervention.

Learning point seven – Safer Sleeping Advice within routine practice

Safer sleeping arrangements are not routinely included in assessments and plans nor included as specific expectations within Child Protection Plans.

Recommendation 10

- Safer sleeping advice should be given, repeated and reinforced by professionals in all agencies both during pregnancy and infancy and carers' understanding of the expectations checked at each meeting. Where there are concerns about co-sleeping in unsafe circumstances, Child Protection Plans should include a specific requirement regarding safer sleeping arrangements.

Learning point eight – Responding to the Voice of the child and their lived experience

The voice of the children was not always heard or responded to and while plans made and services provided may have benefitted them, this was not always designed into assessment or delivery plans that were child focussed and that considered all unmet need.

Recommendation 11

- GSCB to seek assurance regarding how the lived experience and voices of children are heard and reflected in assessments and plans and to address any gaps in practice particularly with regard to disabled children.

Learning point nine – Inconsistent application of thresholds and child protection processes

This review found a lack of consistent:

- application of thresholds, sharing information re: possible concerns or resulting referrals from practitioners to children social care.
- application of child protection thresholds and in holding strategy discussions, initiating section 47 enquiries and convening child protection conferences
- compliance with national and local safeguarding policies, procedures and guidance in relation to referrals and risk assessments across a range of concerns for children in specific circumstances

Recommendation 12

- The GSCE to assure itself that the practice improvements required around thresholds and child protection procedures and processes are made and demonstrating impact for children in similar circumstances.

viii) As part of the assurance received for review as the Overview Author and Panel were given access to several documents in order to consider the improvement work already identified and the progress made on the actions to date. In terms of the systems findings around governance and leadership much work has already been progressed and these improvements have been recognised through Ofsted monitoring visits. Though the pace at which these improvements are delivering consistent and good quality social work support remains an issue. Assurance regarding

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the impact of the actions agreed to meet the findings and recommendations made in this review will be monitored by the GSCE.

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Chapter One - Introduction

1.1 This Serious Case Review was commissioned by Gloucestershire Safeguarding Children Board (GSCB) in respect of Liam and his two half-siblings, Emma and Logan. It provides consideration of the services provided to Liam, his half siblings Emma and Logan and their mother Nicole from December 2012 until Liam's sad death in June 2019 including any relevant background history relating to Nicole and Chris (the father of Emma).

1.1. Liam was one month old when he sadly died suddenly and unexpectedly at home. On the evening prior to his death he was put to bed in his cot by Nicole. During that evening Nicole had smoked some cannabis. During the night Nicole awoke to feed Liam although she could not remember the details surrounding this. She awoke the following morning as usual and was lying on the sofa, as was Liam but who was not breathing. She rang the emergency services who attended within minutes. Liam was transferred to hospital, and despite full resuscitation efforts he was pronounced deceased. A Police investigation took place and was satisfied that there were no suspicious circumstances surrounding his death. The Inquest concluded that Liam did not appear to have any signs of a medical condition and that the cause of his death was unascertainable.

1.2. Liam lived with his mother Nicole and his three-year-old half-sibling Logan from birth. Both children were subject to a Child Protection Plan under the category of Neglect. Logan was subject to a Child Protection Plan as an unborn and following his birth. He and Nicole were placed within a mother and baby fostering place under a section 20 agreement before moving to the maternal grandmother's home for several weeks. Once suitable housing became available Logan moved with his mother Nicole into their own home. Logan remained subject to a Child Protection Plan until March 2016 and there was a further period of support as a Child in Need in 2017.

1.3. Liam and Logan have a half-sibling Emma, who is subject to a Special Guardianship Order and lives with her guardians. Emma had been the subject of a child protection plan under the category of Neglect and Emotional Harm within the first six months of her life due to concerns regarding domestic abuse in her parents' relationship, parental drug misuse and their ability to parent her safely and ensure her wellbeing. There were also concerns about instability in where they were living or staying and a lack of consistency in Emma's care and routines.

1.4. At the age of nineteen months Emma was left in the care of extended family members who were temporarily approved as connected persons under a Regulation 24 Placement. Emma became a looked after child and subject to an Interim Care Order in 2015. Emma remained in their care and became the subject of Special Guardianship Order at the age of two when she ceased to be a looked after child. She has remained in their care ever since. Nicole and Logan initially had contact with Emma, but this is said to have ceased by November 2017. Emma never met Liam but her Special Guardians have told her that she had a half-sibling.

1.5. At the time of Liam's death, he and his half-sibling Logan and their mother, were receiving a range of services including the usual universal services such as health providers through to intensive and specialist services. These included children's social care, early years, education providers, GP services, health visiting, psychology service, paediatric and speech and language services. Nicole was known to the police as a victim of domestic abuse and alleged sexual violence and she was also investigated regarding an alleged wounding although no charges were brought.

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1.6. Liam and Logan's fathers were not known by the services involved with the family. Chris, the father of Emma, had contact with services but did not engage with them. He had no contact with Emma after the contact arrangements broke down in 2016. He was known to the police for a domestic abuse incident and to youth offending services for a common assault. Chris was known to regularly use cannabis and was suspected to be involved in drug dealing and other criminality.

Chapter Two - Background to the review

2.1. Liam's case was considered by the GSCB Rapid Review Panel in June 2019, who made a recommendation to the GSCB Independent Chair that the case met the statutory criteria, in place at the time, for a Serious Case Review. In that under the *Local Safeguarding Children Board Regulations 2006,* for the purposes of *Regulation 5(1*)e under *Regulation 5(2)*:

(a) abuse or neglect of a child is known or suspected; and

(b) (i) the child has died.

2.2. The GSCB Independent Chair, Kevin Crompton, endorsed the decision to conduct a Serious Case Review in accordance with the above regulations and statutory guidance provided by *Working Together to Safeguard Children 2015*.

2.3. The review has been commissioned in line with the principles for Serious Case Reviews set out in *Chapter 4 of Working Together 2015* and aims to contribute to learning and improvement through consolidating good practice and identifying where practice can be improved. The principles for Serious Case Reviews have been in included in the summarised Terms of Reference attached as Appendix A.

Purpose of the review

2.4. The purpose of this SCR is in accordance with *Working Together to Safeguard Children 2015* to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children and young people.
- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and,
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children and young people.

2.5. Serious Case Reviews are not investigations and do not seek to apportion blame or determine any culpability. This review is therefore written from a learning perspective and will make recommendations for practice improvement. It is also written in line with expectations within the *Child Safeguarding Practice Review Panel: practice Guidance (2019)* that Serious Case Reviews are designed to add reflection and learning into local safeguarding systems. The report '*must focus on... why do these themes keep recurring and what can be done to address them?*'.

2.6. The Serious Case Review also considers relevant information from parallel processes in place but will not stray into the territory of these separate statutory processes. Where findings indicate that individual practice calls professional conduct into question this will be a matter

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for individual agencies and their professional bodies to address as required. There have been no such findings in this case. Problematic practice found within this review has already been identified as part of wider systems issues or accepted practice in general at the time.

Practice areas

2.7. The Terms of Reference identified six practice areas for consideration and analysis. It was also identified that there was a common thread of Pre-birth Assessment running through each practice area. The practice areas or episodes are as follows:

Practice Area	Key areas of Consideration
Use of Public Law Outline	Realisation of Nicole's pregnancy with first child, Emma, until Special Guardianship Order granted 25/08/2015.
Child Protection Planning	Effectiveness of Child Protection planning for Emma, Logan and Liam.
Substance Misuse	Effectiveness of the recognising, and strategy planning, regarding substance misuse.
Partnership	The effectiveness of multi-agency working around this family across the time period.
Escalation	Use of Escalation and challenge of other agencies when the child protection plans were not considered effective.
Neglect	The effectiveness of the recognising, and strategy planning, regarding neglect.

2.8. A chronology of the key events and professional practice was analysed within the review. Examination of these key episodes shows the contact with agencies and practitioners and highlighted concerns included neglect, early life trauma, poor conditions within the home as well as a history of domestic abuse, maternal mental health issues and parental use of cannabis. These are detailed within Chapter 3, Analysis of Key Events and Analysis of Professional Practice.

2.9. The individual agencies involved with the review each produced an Individual Management Review report or narrative summary of their involvement which considered the full terms of reference for the review which are summarised and attached as Appendix A.

Family Members

2.10. The contribution of family members has been invaluable in appraising practice around the services provided together with their view regarding what works well or could be done differently in future to achieve better outcomes. The following family members participated in focussed conversations with the Lead Reviewer to explore their view of the services received by the family:

- Nicole - Mother of all three children
- Paula - Maternal Grandmother of all three children
- Andrea - Paternal Great-Aunt and Special Guardian to Emma
- Stephen - Paternal Great-Uncle and Special Guardian to Emma

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2.11. Emma's maternal grandfather was invited to contribute to the review but did not respond to the written invitation and attempts to make contact with him by telephone were also unsuccessful.

Practitioner Involvement

2.12. Twenty-eight practitioners from the agencies listed in the Terms of Reference attended a practitioner learning event in November 2019, many of whom had been directly involved with Liam and his family. The event was also attended by seven Individual Management Review Authors who presented their findings and recommendations to the group. The practitioners then considered in groups the key practice episodes and reflected on what worked well or not, what were the enablers, challenges or barriers to practice and what would they take from this to improve services for children in similar circumstances. There was much productive discussion held with excellent practitioner involvement which was fundamental to the review process.

2.13. The main purpose of the event was to build on the findings from the chronology and to discuss the delivery of services to Liam and his family without any hindsight bias. Participants contributed to the learning from the review through identifying the points at which an action could or should have been taken and why they considered the rationale for decisions made. Good practice was also discussed and its evidence in aspects of current practice. Appendix B provides a summary of the learning generated by participants. Informal feedback from this event has been positive around the reflective learning gained while some practitioners expressed that it had been professionally challenging for them and support was offered to them both on and after the day.

Relevant background prior to scoping period

Period	Key Information
1996	Nicole was born early in 1996. The records show an enquiry was made to the Child Protection Register two months after her birth. However, there is no information in the Children's Social Care records regarding the concerns held or the circumstances that led to the enquiry or its outcome.
2002	When Nicole was 6 years old, the police undertook a welfare check following an allegation made by her father regarding 'undue smacking' by her stepfather, who it was alleged smacked Nicole on her legs, bottom and around her head. Nicole's birth father stated that he did not intend to return her from contact and the police advised her mother accordingly. It was agreed that social care would attend in the first instance. The stepfather admitted the smacking to the social worker and agreed to work with them. The outcome of this is not known from the records.
Autumn 2009	Aged 13 years old, Nicole disclosed to her school that there had been an incident at home where, following her arguing with her mother, her stepfather had used physical force to drag her out the room leaving a mark. When she had run upstairs to her bedroom, it was said that he ran upstairs after her and was verbally abusive to her. Her aunt and uncle then arrived, and he went downstairs. There is no detail of what the response to this disclosure was.
Autumn 2009	Around this time, school shared concerns that Nicole had emailed an image to a boy who then sent it on to other pupils in the school. There were also concerns that Nicole had possibly been coerced into participating in a game of 'Truth or Dare' in the park with three boys. The police investigated the incident and

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Period	Key Information
	concluded that it was not in the public interest to pursue the matter and advice was given. It was also reported that her stepfather had given her mother an ultimatum to choose between them. Further concerns were noted regarding Nicole not wanting to spend the weekend with her father as he 'shouts and swears too much' and she made reference to his use of cannabis.
Spring 2010	During this period 'keeping safe' work was undertaken with Nicole. In January 2010, while still aged 13, Nicole took an overdose and was taken to hospital by her mother. Nicole would not talk about why she had taken the overdose although a referral was made to CAMHS for support.
Spring 2010	Two months later when Nicole had just turned 14, school shared concerns that she had been seen drinking alcohol in town and they were also concerned that Nicole was being encouraged by her peers into being sexually active. At the time she was seeing a school counsellor and saying that she did not want contact with her father. The case was briefly opened and closed to Children's Social Care in April 2010.
Autumn 2010	School contacted Children's Services because Nicole had reported that her mother had smacked her across the back of her head after she had not attended school. Children's Social Care took no further action as Education Welfare, Community services and others were working with Nicole at the time.
Summer 2011	When Nicole was 15 years old, a referral was made to Children's Social care as there was concern that Nicole could not '*keep herself safe*'. At the time Nicole was in a sexual relationship with a man aged 22. Nicole also reported an earlier incident where another man had refused to let her leave his car until she had performed a sex act. Nicole's father said he was concerned about her as he had been told that Nicole was having sex with older men and she had stayed overnight at the home of a man who was within the criminal justice system.
Autumn 2011	A Strategy Meeting was held due to the concerns that Nicole was vulnerable to child sexual exploitation and online grooming from older men. In late 2011, Nicole's case was transferred to the locality social work team because of her vulnerability to sexual exploitation, which was described at the time as '*risky sexual behaviour*'. The social care records of what work followed are limited in their detail.
Spring 2012	A referral was made to Youth Support Team (YST) in January for early help by the locality Children and Families Team. Nicole was referred as '*seeking the company of older men*' and was being subjected to Child Sexual Exploitation. The case is closed by the Children and Families team in February as Nicole is now being supported by YST.
Spring 2012 onwards	Nicole engages with the service around self-esteem, healthy relationships, sexual health and education, employment and training (EET) but is said to be reluctant to follow the sexual health advice given. Nicole discloses alcohol and cannabis use and is referred to 'infobuzz'. The main concern is Nicole using alcohol to increase her confidence and lower her inhibitions to meet men. There is no record of this being reported or jointly investigated with the Police. It is suggested by YST that, due to her poor relationship with her parents and stepfather, Nicole's emotional needs are not being met and she is seeking to be 'loved' elsewhere.
Autumn 2012	Nicole informed her Youth Support worker that she is now in a relationship with Chris.

2.14. This snapshot provides a context of the difficulties experienced in Nicole's own childhood including relationship breakdown, poor mental health and self-harm as well as child sexual

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exploitation. A wealth of research has highlighted strong associations between adverse childhood experiences and the likely impact on parental mental health and wellbeing and parenting capacity[1]. While information regarding the work completed with Youth Support was appropriately shared in 2013 with other professionals working with Nicole, how it was considered in assessments or underpinned planned work with the children is considered in the periods of concern under review.

Other relevant contextual information

2.15. In 2017, the Ofsted Inspection of Gloucestershire County Council's services for children in need of help and protection, were judged to be 'inadequate'. The report highlighted that '*Inspectors found that services for children in Gloucestershire have deteriorated since the last inspection in February 2011. This means that children who need help and protection do not always have the right help, at the right time, to keep them safe*'. Since this time, the Local Authority have had an improvement focus and have made changes to their leadership and governance as well as their processes, procedure and practice requirements as outlined in the Ofsted monitoring visit letters.

2.16. This Inspection also found that the Gloucestershire Safeguarding Children Board '*requires improvement*' to meet its statutory functions and several recommendations were made based on their findings around a lack of practitioner knowledge and understanding of learning from Serious Case Reviews, limited escalation of concerns and the poor professional response to neglect.

2.17. Gloucestershire Safeguarding Children Board have been working on these recommendations since this time and have enhanced their multi-agency training programme as a result. They have also undertaken several serious case reviews, which appraise the multi-agency practice around neglect and pre-birth assessment, which have similar case characteristics or factors to this case. These reviews have been considered against the findings found within this review and identified that these reviews have also made similar findings and have detailed action plans in progress.

2.18. In accordance with legislation and revised statutory guidance, Gloucestershire Safeguarding Children Board was abolished and replaced by their revised *Multi-agency Safeguarding Arrangements* on 15 July 2019. As part of these arrangements the three statutory safeguarding partners Gloucestershire County Council, Gloucestershire Constabulary and Gloucester Clinical Commissioning Group formed the Gloucestershire Safeguarding Children Executive (GSCE) with the Independent Scrutineer providing an overview and objective challenge.

2.19. The GSCE is now responsible for ensuring each agency works together to ensure children are kept safe from harm and that the welfare of all children is promoted by putting the health, welfare and wellbeing of children and young people at the forefront of everything they do. As part of this, they are responsible for ensuring that safeguarding policies are in place, evaluating their effectiveness and making sure lessons learnt from Serious Case Reviews are embedded and that all previously agreed improvement activity is concluded and demonstrates impact.

2.20. Therefore, assurance regarding the impact or progress on actions from existing recommendations either from Inspection or Serious Case Reviews has been sought and

[1] Routine enquiry about childhood adversity (REACh) across mental health, sexual health and substance misuse services (HM Government, 2015)

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considered by the Lead Reviewer and Serious Case Review Panel before making the recommendations within this review.

Chapter 3 - Appraisal of Practice

3. Narrative chronology

3.1. The following sections are informed by an integrated chronology of events and the Individual Management Review reports of agency contacts with Liam and his family that were provided to the Serious Case Review Panel. These documents build a picture of the children's life stories and lived experience and in understanding who was involved in their care, what actions and decisions they made and why. The practitioner event and focussed conversations with the family members also assisting in providing a richer understanding of the family's experiences of the agency involvement and receiving services from a range of universal, targeted and specialist services.

3.2. The narrative chronology is therefore divided into six time periods which each consider the key episodes according to the Terms of Reference. As highlighted above relevant background prior to the timeline for the review is considered including Nicole's own childhood history and the period leading up to the birth of Emma and the significant events from the time she and Logan were born until Liam's sad death at one month of age. In seeking to be proportionate, not every chronology entry is included and key events are further analysed within this section to show how the concerns developed over the six periods identified , together with the appraisal of the professional action taken including relevant input from the agencies, practitioners and family members who participated in this review.

4. Realisation of Nicole's pregnancy with her first child, Emma, until Special Guardianship Order granted 25/08/2015.

4.1. Nicole booked for antenatal care in early October 2012 when she was nine weeks pregnant. This was noted to be her first pregnancy and the Community Midwife asked the routine questions required regarding domestic abuse and her living situation. It was established that Nicole had a history of cannabis use and poor mental health. Nicole shared that the father of the baby, Chris was also 16 years old and that he was said to have ADHD and known to use cannabis. It was also noted in the booking record that there were social housing and money issues and that a named Youth Support worker was involved. A referral was made by the booking midwife to the Teenage Pregnancy Midwives and a plan made to follow the normal pathway for a first-time mother.

4.2. Nicole's Youth Support Worker noted that Nicole was in a relationship with Chris and seeing him exclusively but also noted that his influence on her was '*stronger*'. Nicole was staying with him more, predominately at his grandfather's address, and Chris was reported to be 'more settled' while staying there. Nicole's worker continued Education, Employment and Training support and started pregnancy support with Nicole to prepare her for the birth as well as reviewing her accommodation options. Nicole was noted to be homeless and living between family members. Tensions in the relationship with Chris are recorded and that, because of this, Nicole was undecided between a placement in a mother and baby unit and living with Chris.

4.3. Nicole did not attend her first scheduled appointment with the Teenage Pregnancy Midwives but attended a routine antenatal appointment with the community midwife in late December

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2012. This appointment was rearranged for early January 2013 where Nicole discussed with the teenage pregnancy midwife that she was currently living with her mother and four siblings (the youngest being 9 weeks old). She also shared that she had overdosed at fourteen and referenced her experience of bullying at this time and her difficult relationship with her father and stepfather.

4.4. At her next antenatal check in February, Nicole advised the community midwife she was now staying with Chris at his mother's one-bedroom property and that she was planning to attend *Young Mothers to Be* in her locality. However, at her next appointment with the community midwife in March, Nicole reports that she is mainly staying at her mother's house because of threatening behaviour by people towards Chris at his mother's address.

4.5. At the end of March 2013, a referral was noted as received by Children's Social Care regarding Nicole being pregnant, however, there is no corresponding outcome or entry in the combined multi-agency chronology, so if one was made, it is not known why, by whom or what the concerns were. Therefore, consideration of a pre-birth assessment which over time could have supported a fuller understanding of the care Emma was likely to receive and what support would be required to ensure her needs were met was not made.

4.6. Nicole did not attend her appointment with the teenage pregnancy midwives in April as she advised she was unwell, nor did she attend the rearranged appointment in May. Following liaison between the two midwifes the appointment was left 'open' which meant that a referral back to the teenage pregnancy midwives could be made at any time. It appears from the combined chronology that her non-attendance was not shared with other professionals.

4.7. Nicole was next seen for routine antenatal care by the Community Midwife in early May 2013 and nine days later was admitted in labour with Emma. Nicole was discharged back to her mother's address three days after birth. When the community midwife visited the following day, it was noted that Nicole was sleeping on the sofa in the lounge, safe sleep advice was given to Nicole regarding not sleeping on the sofa with Emma.

4.8. The grandmother's property was overcrowded when Nicole and Emma were staying there hence them living and sleeping in the lounge. Both Nicole and her mother advised the practitioners working with them that sleeping in the lounge presented challenges to them in terms of reduced living space and maintaining family routines. This was not considered as an unmet need which might benefit from an Early Help Assessment or a referral to Children's Social Care for Emma and Nicole as a child in need. Nicole was routinely seen by the community midwife at home and at two-weeks old Emma was said to be feeding well and gaining weight. Her care is handed over to the health visitor and no identified vulnerabilities were shared.

4.9. Soon after this visit Nicole informed her YST worker that they are '*mostly staying*' with Chris at his sister's property where they were again sleeping in the lounge. Nicole also shared that she was finding her '*father controlling regarding his views about Emma*'. However, the records do not expand on this nor does it appear that this information was shared with any professional or explored further in terms of whether there were any risks to her or Emma in no longer staying with her mother. Nor indeed, as to whether her father held any legitimate concerns regarding the care and parenting being provided to Emma, as this information could have been shared and explored.

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4.10. In early July, Nicole made a complaint to the Police regarding her father sending threatening texts regarding Chris. Based on the initial report it was determined that this was a dispute regarding access to his grandchild Emma and advice was given to Nicole to block his calls. This decision appears to have been made on the basis that her father did not know where Nicole was living at this time so there was no imminent danger of harm to her.

4.11. Consideration of any potential risks to Emma as a vulnerable baby was not evident. The opportunity to consider the situation in more detail and to identify any other relevant factors to this episode was missed. Had her father been spoken to regarding Nicole's complaint he may have been able to offer some insight into his concerns for Emma and the quality and stability of care provided to Emma. It would also have been an opportunity to advise him regarding his interactions with Nicole and to set expectations around this. No information was shared with other practitioners regarding this episode as it was not identified as a child protection concern.

4.12. Nicole and Chris continued to move from place to place with Emma. In early August 2013 concerns were noted by the Youth Support worker that Emma did not have any clean clothing nor the baby equipment necessary to meet her needs. However, this instability did not seem to be considered in terms of risk or need for Emma. There was also no consideration apparent that Nicole, who was not yet an adult herself, may have been experiencing coercive control as Chris had locked her in a room while pregnant and there were said to be '*tensions in the relationship*'.

4.13. Nicole took Emma to stay with Chris's family and on her return, was reported to appear dishevelled, which was very unlike her. It was recorded that Nicole was '*meeting Emma's basic needs and she is doing well however, Emma and her mother need more appropriate living conditions to provide stability so as Nicole is able to ensure she is able to continue to meet all of Emma's growing needs'*. However, it is difficult to see how even Emma's basic needs could be properly met with Nicole's transient lifestyle and Emma who was not yet three months old and entirely reliant on her parents to provide for her care and keep her safe.

4.14. Children's Social Care were invited to a professionals' meeting convened by the Health Visitor. Emma was noted to have lost weight. Nicole attended the meeting but minimised the concerns and stated she would call the Police if she again felt threatened by Chris. The plan was for continued support for Nicole by Youth Support and the Health Visitor for Emma. This outcome appeared reliant on self-reporting by Nicole regarding any risks in the relationship with Chris and on her assurances that Emma would not be exposed to cannabis.

4.15. Therefore, it would be reasonable to assume that Emma would likely be exposed to cannabis and instability if Nicole continued to stay with Chris at his mother's. This plan also relied on Nicole securing accommodation imminently and that once in her own accommodation, Nicole would be able to prioritise Emma's needs over her own and resist being with Chris. This demonstrated a lack of insight into the dynamics of abusive or coercive relationships identified in other local reviews.

4.16. Nicole and Emma moved into bed and breakfast accommodation but then moved into flat at a supported housing unit in a neighbouring town. The unit housed young mothers aged 16-25 with their babies. However, within three days Nicole had left the unit and returned to her hometown to be with Chris and her social support network. She was returned to the unit with Emma by her Youth Support Worker. This began a pattern of Nicole not attending sessions and she was absent from the flat for increasing periods of time throughout September and October. Emma was not brought for immunisations and there were concerns from the Children's Centre

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about Nicole's ability to effectively parent Emma. However, no referral was made to Children's Social Care.

4.17. As Nicole was now spending most of her time away from the unit at Chris's mother's home, she was at risk of losing her own flat. This information was shared by Youth Support with Children's Social Care together with known concerns regarding Emma being exposed to cannabis smoke and possible aggressive behaviour from Chris. Housing support workers at the unit put a plan in place to ensure that Nicole understood what was expected of her in prioritising Emma's needs over her own or Chris's.

4.18. It was agreed that if she were missing from the flat that she would be contacted and her whereabouts ascertained each day. Workers told Nicole that, if they had any suspicion that she was at Chris's house a visit would be made there, or a police welfare check would be requested to ensure Emma was not present there. However, despite Nicole regularly being absent from the flat a Police welfare check was not requested, nor referred to Children's Social Care.

4.19. In early November Nicole returned to the unit with Chris as a visitor. For the rest of the month she and Emma were absent from the flat. To the consternation of those working with her, despite very strong recommendations to remain living at the unit in order to access the support available to her, Nicole decided to give up her tenancy and stay elsewhere. In late November, Children's Social Care also received anonymous information that groups of adult and adolescent males were regularly visiting Chris's mother's property at all hours and of loud and anti-social behaviour on a regular basis. Concerns were raised regarding Emma being present there. A strategy meeting was held, although her Youth Support worker was not invited despite holding key information, which was an oversight. However, it was agreed that the threshold for section 47 enquiries was met and an initial assessment was commenced by Children's Social Care.

4.20. The social worker who visited Nicole felt that she was meeting Emma's basic care needs although the constant moving around, and resulting instability, was having an impact on Emma. The assessment correctly identified how this might impact on the quality of care, support provided and monitoring of Emma by health professionals. Concern was also noted as Emma was losing weight. The social worker observed that Nicole believes she can control Emma not being around Chris or his associates when drugs were used, or aggressive and anti-social behaviour was displayed. The social worker summarised *'... it is clear that she and Emma are vulnerable and that if as she plans, they all live together in a private rented property this does not appear manageable or safe*'. Despite this recognition of vulnerability, it did not recognise that Emma and Nicole were already spending considerable time with Chris in unsafe circumstances.

4.21. In early December, Nicole called the social worker saying she was staying with Chris at his sister's house. It is not known why there was no curiosity and assessment of whether this was safe environment for Emma. The information was shared with housing and the health visitor. Chris's mother then moved to a two bedroomed property and she confirmed Chris would be staying there temporarily until he and Nicole could find their own place to rent. While this could be viewed as seeking to comply with the social worker's expectations to live separately there was no further engagement by Chris and his mother with the social work assessment as pre-arranged visits were cancelled and there was no response to unannounced visits.

4.22. The social worker was therefore unable to assess Chris's parenting capacity or obtain his view of the concerns nor check whether Emma was present with him at his mother's or not. However,

the social worker for Chris's sibling who was also subject to a plan confirmed that, when visiting the residence, Chris came out of his bedroom it smelt very strongly of cannabis and that Nicole and Emma were also in that room.

4.23. An Initial Child Protection Conference was held in early January 2014 and Emma was made subject to a plan for neglect and emotional harm. Throughout the next few months there were significant concerns for the welfare and safety of Emma while in the care of Nicole and Chris. Further detail regarding the period that follows is included in the practice appraisal of child protection planning in Section 5 below. In summary there are continued concerns regarding missed health and other appointments, parental cannabis misuse and alleged drug dealing from Chris's family home. There is alleged physical violence by Chris, which Nicole later confirms to Police when they are called as Chris is seeking to take Emma from her. There is also an allegation by Nicole of sexual violence by Chris which she subsequently withdraws.

4.24. Chris's family home where they were staying much of the time with Emma was known to be chaotic with frequent visitors throughout the day and night and neighbours reporting anti-social behaviour. There were additional concerns regarding Nicole taking Emma with her when she was associating with street drinkers and that Emma had no routines and was often out with Nicole when she should be asleep in bed.

4.25. Nicole was encouraged to move with Emma to live with her paternal aunt and uncle in October. However, concerns in relation to Nicole's parenting of Emma increased after this move as further concerns were reported regarding Nicole ignoring and not meeting Emma needs. At the Review conference in early December, a legal planning meeting is agreed for two weeks' time and it is decided that Emma will remain subject to a plan and remain living with Nicole at her Aunt's home. Chris is to arrange contact with Emma via the Social Worker.

4.26. The Legal Planning Meeting was held, and advice given that threshold was met to enter pre-proceedings based on the mother's substance abuse and neglectful parenting behaviour. The local authority formally placed Emma with Nicole's aunt and uncle at the end of December 2014.

4.27. At the end of December, Nicole signs a section 20 agreement for Emma to remain in the care of her great-aunt and great-uncle until she sorts herself out. This arrangement was regulated as a *Regulation 24, Connected Persons* placement, which meant that Emma became looked after by the local authority. The great-aunt and great-uncle were given temporary approval as local authority foster carers pending an assessment and a care planning decision being made for Emma.

4.28. However, despite Nicole not having stable housing and in effect being homeless she is said to '*disappear with Chris*' and it is recorded that she has '*abandoned Emma*' in leaving her with her great-aunt. It does not appear this dialogue is questioned by professionals given that Nicole is known to be depressed, experiencing domestic abuse and pregnant with Logan.

4.29. A second pre-proceeding meeting is held and neither parent attends. As the parents are not exercising their parental responsibility nor engaging in the legal process, legal advice is given to issue care proceedings. In March 2015, the Local Authority made an application in Care Proceedings and an Interim Care Order was made in two weeks later. It is not clear why it took three months from agreeing the threshold was met to issue proceedings. There continues a

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period of assessment and support for Emma with legal proceedings with the plan being for Emma's great-aunt and great-uncle to seek Special Guardianship.

4.30. Subsequently, on 25th August 2015, supported by the Local Authority, the court made a Special Guardianship Order to them. Nicole and Chris did not fully engage with the assessment in proceedings but as the placement was with family and contact was said to be not contested a contact order was not thought to necessary. The agreed plan for contact with Emma was for fortnightly contact with Nicole and Logan, to be facilitated by her Special Guardians.

4.31. This period identifies some areas of learning for practice improvement that appear to be features of practice in general at this time. There was a significant delay in securing the multi-agency safeguarding response during this period and despite practitioners having significant concerns there was no formal referral to Children's Social Care until late 2013. Therefore, although information was shared with them and a professional's meeting was held earlier in August there was no pre-birth referral and no joint pre-birth assessment once it was known that Nicole was pregnant.

4.32. There was a Pre-Birth Procedure and Thresholds of intervention document in place at the time however, these were not well known or understood, and the previous unborn policy was said not to make the roles and responsibilities of different agencies regarding assessment and planning clear. The approach to pre-birth assessment and planning is explored in more detail in the practice appraisal in the following section for child protection planning for Logan and Liam.

4.33. However, when realised, the plan for Emma to stay at her great-aunt's rightly sought to ensure that her basic daily living needs would be met and to protect her from instability and trauma. It could have been strengthened by further consideration of how the separation from her parents might impact on her identity and attachment development. While it made reference to contact it was not clear how Emma would be supported to maintain contact with Nicole given her transient lifestyle. The decision record states, '*Mum will need to focus on meeting her own mental health needs and those of the child before consideration could be given to mum resuming care of the baby'.* However, it was silent on the plan to assess whether reunification with Nicole was a possibility if, and when, she was able to sustain demonstrable improvement in her poor mental health and living circumstances, such that she could safely and effectively care for a child. The plans for permanency and ongoing contact could therefore have been strengthened.

5. Effectiveness of Child Protection planning for Emma, Logan and Liam.

January 2014 – November 2014: Child Protection Planning for Emma

5.1. In January 2014, now aged nineteen months and subject to a Child Protection Plan, Emma and Nicole were transferred back to services in their hometown. The Health Visitor undertook a '*Schedule of Growing Skills*' (SGS) developmental assessment of Emma and identified she was developing as expected. The Youth Support worker resumed her work with Nicole focussing on housing and EET support. Nicole and Emma are to live with her mother until she can access 18+ independent living. Between January and March there are a several missed appointments such as for Emma's immunisations and several no access visits. However, Nicole engaged with EET support and at the end of the month it is realised she has been leaving Emma with a friend at the weekend so she can stay with Chris. The Core Group meets and seeks for Nicole to provide stability of care for Emma.

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5.2. In March, Nicole disengages with services and moves around family and friends, and then moves into Bed and Breakfast accommodation with Emma. Emma was again not brought for her immunisations. Concern is shared following core group that Chris has an autistic spectrum disorder and that he cannot pick up on Emma' needs and he may need help with parenting as '*during the core group Emma went to him several times and he ignored her*'. At this point there had been no assessment of his parenting due to his lack of engagement. The Review Child Protection Conference decides that Emma should remain subject to a plan as there are still concerns around Nicole's engagement and stability. Nicole reports her relationship with Chris has ended although she resumes it shortly after.

5.3. Nicole attends an emotional wellbeing course arranged via the Family Support Worker. The social worker encourages Nicole to attend the Children's Centre, but she says she finds it difficult attending groups with people she does not know. The new Health Visitor is unable to access Emma at visits and Nicole has still not brought Emma for her immunisations. At the Core Group it is shared that Emma is still not registered at a GP surgery and they are in temporary accommodation, as well as staying with maternal grandmother on the sofa at times. Chris is known to be visiting Nicole at her temporary accommodation and admits to leaving Emma with him.

5.4. Although both parents are not cooperating with the plan there is no consideration of a legal planning meeting. Nicole moves into a two-bedroom property in the town centre and she is supported to access financial and tenancy support. Nicole self-refers to a psychoeducational emotional wellbeing course but only attends the first session. As she did not give details or her GP or address on the registration form this information could not be shared with core group members. There were several no access visits and when the Health Visitor did gain access Chris was present there with his Staffordshire Bull Terrier and the house smelt strongly of cannabis.

5.5. The Youth Support worker conducts a home visit and finds Nicole has left Emma with Chris while she is out shopping, and Chris is staying at the property a lot despite it being in contravention of the child Protection Plan. Concerns were raised at Core Group that Emma's Immunisations are still outstanding and Emma is not registered at a GP surgery. Subsequently Emma and Nicole are registered at same GP practice.

5.6. Nicole reports to the Police that Chris has locked her out of the house after she went out against his wishes and Chris has taken Emma with him. Officers attend and recognised this as a domestic abuse incident. Chris returns with Emma before Officers arrive. Nicole states there had been no violence in the relationship and that Chris did not take drugs, but he was controlling, and his temper frightened her. As there were no signs of a disturbance or injury to anyone, Officers asked Chris to leave and a DASH form was completed. However, there were clearly identified risks to Emma given that Chris was already on bail and there were drugs and mental health warnings attached to his Police information. Given this cumulative risk this should have resulted in a joint strategy discussion with Children's Social Care taking place.

5.7. At the Review Child Protection Case Conference in June, despite the growing evidence of the risks that Emma is continuing to be exposed to, a lack of tangible progress and cooperation there is no consideration of a legal planning meeting. Throughout the following months the concerns continue around drug use by Chris and other people and regarding the general neglect of Emma. Nicole discloses to the housing worker that an unnamed previous partner raped her

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and then retracts the disclosure, so it is not reported. She is referred to a counsellor, Nicole then disengages with Youth Support and there is no contact. However, Nicole then also discloses non-consensual sex with Chris to Health Visitor, this is appropriately shared and referred.

5.8. Nicole formalises the allegation of rape against Chris and it is investigated. Following her interview, it could not be established whether there was consent or she was coerced and the evidence available did not meet the standard required to support a prosecution. However, the investigating Officer was very concerned about Emma, then aged 15 months, as it was evident from Nicole's own account during her interview that Emma had no routine and she was taken out with her in the early hours when she should be sleeping, the crime scene investigator was concerned about the messy state of the house. Although the officer in charge of investigating the rape was not a child protection detective, she recognised Emma's vulnerability and need for multi-agency support. Her concerns were shared with Emma's social worker and this is recognised as effective practice.

5.9. The following day an unannounced joint visit took place with the social worker to check on Emma's welfare. On arrival there was another girl sleeping on the sofa and Nicole was asleep. Emma had just woken up and the house was very messy, and it was '*evident they had been up all night watching films, eating and drinking*'. The Police records suggest the Social Worker planned to call a strategy meeting with a view that Emma may be removed from the home if her circumstances do not improve. However, a strategy meeting does not take place until three months later with further drift and delay and a lack of decisive action taken to safeguard Emma.

5.10. The second SGS development assessment was undertaken with no developmental concerns being identified by the Health Visitor. Nicole was referred to the Recovery Team for mental health support, but the Health Visitor was advised that Nicole should instead be referred to the Primary Mental Health Service (PMHS) by her GP. Accordingly, the GP made the referral regarding Nicole's '*problems with anger, irritability, anxiety and depression*' and advised she had been started on an antidepressant. Despite the GP recording that Emma was subject to a Child Protection plan this information was not shared with the Social Worker. As there was no response from Nicole to telephone calls or letters from the PMHS she was discharged.

5.11. Concerns of neglect and poor home conditions continue, with Emma's hair observed by the Health Visitor to be '*matted with dirt'*. Also, that she was *'wearing a dirty nappy... the house smelt of cat excrement'*. Nicole shared she goes out all day and then comes home late at night and they both just fall asleep. She informs the Health Visitor she has low mood and discloses a history of self-harm and suicidal thoughts. This is discussed at core group and it is agreed that the concerns will be addressed at the Review conference in five weeks' time, with close monitoring to take place by the social worker and health visitor. There is no apparent dissent or escalation of this decision.

5.12. Nicole contacted the Police stating her father was trying to remove Emma as he was concerned about where she is taking her. It is identified that this was at a playground with a reputation for drug use and street drinking. Advice is given to Nicole and a referral made to Children's Social Care. While the incident recognised that Emma was subject to child protection, it again does not appear there was consideration of whether Emma's presence during the incident was significantly harmful, and this is not explored with him by any agency or at core group. The

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same month there are reports that Nicole has ended her relationship with Chris and that she is having sexual contact with other men while Emma is in her care. The Youth Support worker visits the home and is concerned about the state of the property and reports that Chris may be 'dealing' from the house. It therefore is again decided that a strategy meeting is required but it did not take place for a further three weeks later which was an unacceptable delay.

5.13. Nicole contacted the Police to complain about her father shouting and when contacted by the Police regarding this he raised concerns that Emma is being neglected despite him looking after Emma to give Nicole an opportunity to tidy the home, Nicole had failed to use the time to get the house into a suitable liveable condition. He advises that as a result, he was not prepared to allow Emma to return to the house. The Police shared this information with Children's Social Care, however, there is no corresponding record of this or a response to these concerns. There is no consideration that Emma's grandfather may be a protective factor or hold significant information.

5.14. There are continued reports throughout September and October that:

- Nicole has been seen with street drinkers in the presence of Emma on three occasions
- unknown males are regularly in the home
- Emma is observed as being unkempt and dirty
- cannabis is being used in the home and is visible on visits
- home conditions are poor.

The above concerns are discussed at core group although the actions within the plan remain unchanged. This outcome therefore does not recognise the continued vulnerability of Emma, the ongoing neglect nor does it consider the cumulative risk that she is being exposed to. This practice episode reflects the system failures known to be present at the time.

5.15. Nicole is seen by her GP as she is now pregnant with Logan. Throughout October Nicole is often missing from her property with Emma, sometimes for days at a time. Nicole then moves to live with her paternal Aunt at the request of the professionals involved. Nicole tells her Youth Worker that she still wants a relationship with Chris, although she agrees to a referral to GDASS[2] for support regarding her experience of domestic abuse. Nicole also reports she is having ongoing problems with Chris as he is constantly phoning and sending threatening text messages regarding harming the father of her unborn baby. While a DASH is completed, and a welfare check made on Nicole by the Police, it does not appear Chris is spoken to. There is also no recognition or recorded response from the multi-agency partnership that, according to research[3], domestic abuse victims are at increased risk when pregnant as well as on ending a relationship.

5.16. Nicole is at risk of eviction and decides to vacate her property and move back to her mother's house after staying for two weeks with her Aunt. Nicole books with the midwife and advises that she previously used cannabis and there was domestic abuse in her previous relationship. She advises that she is with a new partner although they are not the father. Their details are not recorded nor is there professional curiosity evident regarding this as to whether they are caring for Emma or likely to involved with the unborn. Positively, Nicole is referred to the Teenage Pregnancy Midwife and a Consultant Obstetrician and information is shared with her GP and Health Visitor for Emma.

[2] Gloucestershire Domestic Abuse Support Services
[3] 'SafeLives'

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5.17. Several concerns are expressed regarding how Nicole will meet Emma's needs at her mother's house, and she agrees she will return to her Aunt's house. Nicole reported she was not keen to return to her Aunt's, as her father was always visiting, and she did not feel enabled to parent Emma while there. A referral is received from Environmental Health regarding the conditions in the property where Nicole and Emma are staying including being exposed to cannabis use, cultivation and dealing as well as concerns about domestic violence as '*the property is littered with holes in doors and walls'*. Children's Social Care liaise with the health visitor and are recorded as stating they will explore an Emergency Protection Order to keep Nicole at her Aunt's and will carry out a parenting assessment. A strategy meeting is held in late November. Nicole disengaged with Youth Support and other services at the end of the month until mid-December.

5.18. In early December 2014, a Review Child Protection Conference was held with Emma remaining subject to a Child Protection Plan. It was agreed that Nicole and Emma would stay at her aunt's house and Chris was to arrange contact through a social worker. There was little progress with the plan or cooperation with it by Nicole and Chris and consideration of a legal planning meeting was recorded. It also appears that Nicole was warned that Emma would be removed from her care if she did not comply with the plan. Nicole was 12 weeks pregnant with Logan.

5.19. Police attended at Nicole's Aunt's address as Chris had visited there wanting to see Emma that morning, he had left when asked by Police but then returned that evening. The attending Officers completed a DASH form and graded this as 'standard risk'. Officers perceived a level of 'disguised compliance' with Nicole wanting Chris to see Emma. Nicole stated to officers that she wanted Chris in her life but to be '*clean of his habits*', there is no detail what she meant by this. The officer showed insight and expressed a concern that Nicole may feel sorry for Chris who could '*use his homelessness as a form of emotional abuse*' however, they did not consider if there was a pattern of harassment from Chris and it was not recorded as a crime.

5.20. Two days later Police received information that Nicole had taken Emma to stay with Chris at his mother's address. When they visited the property an '*overwhelming smell*' of cannabis was described. Nicole's attitude was said to be '*Cavalier*' when the risks were outlined to her and she was informed she could risk arrest for child neglect. As Nicole agreed to return with Emma to the great-aunt's home the Police did not consider that use of their section 46 powers[4] of protection was necessary. The officers contacted the Emergency Duty Team (EDT) and, although there was evidence of a likely risk of significant harm to Emma, the agreed outcome was to send the information through to Children's Social Care.

5.21. Nicole and Emma were returned to her Aunt's house and it was made clear to Nicole by Officers that this was her last warning and if she was found in the presence of Chris or his mother with Emma again this would '*more than certainly result in Social Services removing Emma from her care'*. While this outcome ensured that Emma was removed from the immediate risk, given the previous history there was a distinct possibility that Nicole would take Emma back there again.

5.22. Whilst recognising the circumstances as potentially being criminal neglect and that children's social care might remove Emma if it happened again, the Officers appeared not to recognise the ongoing chronic neglect, likelihood of significant harm and that a strategy discussion was

[4] Section 46, Children Act 1989

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required to consider whether the threshold for section 47 enquiries or an EPO was met. Therefore, the EDT's incorrect response was not challenged or escalated. However, practice appraisal in the analysis meeting highlighted that, as Police are not part of Core Groups and Review conferences, they are not aware of continuing concerns nor are they party to contingency planning for children subject to plans. This is the subject of a recommendation within the Police IMR Report.

December 2014 – March 2015: Formal placement for Emma and legal proceedings issued

5.23. The Core Group is held a few days later and it is recorded that an Emergency Protection Order is not required as Nicole wants Emma to remain at her Aunt's '*until she sorts herself out*'. A S20 written agreement is signed by Nicole that she will leave Emma with her great-aunt when she goes out. Contact for Chris to see Emma is to be arranged with the Social Worker.

5.24. The first Legal Planning meeting takes place and advice given that threshold is met and to enter into pre-proceedings '*on the basis of the mother's substance abuse and neglectful parenting behaviour'*. It is not known how Chris was considered as part of this process as a person with equal parental responsibility.

5.25. A Review conference is held, Emma remains subject to plan as she is now looked after and within Family Court proceedings. At the Looked After Child Review it is agreed that Emma to remain with her great-aunt and contact is arranged to take place for two hours per week for each parent. As part of pre-proceedings, parenting assessments will be undertaken on both Nicole and Chris.

December 2014 to June 2015: Pre-birth planning for Logan

5.26. Nicole was seen by maternity services and referred to a teenage pregnancy midwife who was advised that Nicole would need as much support as possible '*as legal proceedings were due to start with respect to Emma*'. Her view was that Nicole will be unable to meet the plan for Emma due to her low mood and depression and that Nicole has since ceased her medication due to worries about the effect on the baby. It was agreed Nicole would attend the GP to discuss a prescription for antidepressants and to agree for referral to 'Let's Talk' and information and guidance service for emotional wellbeing.

5.27. During January 2015, Nicole who is now four months pregnant with Logan, is found to be living with Chris at his mother's and her mental health is said to have deteriorated. She tells her Youth Worker she is struggling emotionally with her situation. During this period, a significant number of appointments were not attended by Nicole including antenatal care, the pre-proceedings meeting and first Looked After Review for Emma. When she is visited by the Community Midwife at Chris's mother address she is noted to '*very pale, low in mood and uncommunicative*'.

5.28. Both Nicole and Chris are reported to be thrown out by his mother and sofa surfing while staying with a friend. Concerns are shared that Nicole maybe involved in drug dealing. There is liaison between the Teenage Pregnancy Midwife and the social worker who is extremely concerned as Nicole has not been seen by professionals or family for several weeks. It was agreed that if Nicole does not attend her anomaly scan the following day she will be reported as a missing person and referred to adult social care.

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5.29. Nicole does not attend the scan, and her mother is contacted, who advises she is in contact with Nicole every few days, however she will not tell her where she is staying. Despite Nicole's whereabouts and wellbeing being unknown there is no consideration of a strategy meeting for Logan as an unborn child, as would be required by the GSCB procedures in place at the time. Instead a plan is made to rearrange the anomaly scan for the following week and to report Nicole missing then if she does not attend. Nicole attends the scan and advises she is again staying with her mother. This seems to allay the concerns for Nicole and the unborn baby,

5.30. Nicole requests assistance through her mother to leave Chris and is collected from town by her Youth Support worker who links her with GDASS and returns her to mother's address. She discloses that Chris had physically assaulted her, however this does not appear to result in any liaison with police and the social worker for consideration of a strategy meeting. Nicole then leaves her mother's house again and returns to previous address which is still unknown. At the core group meeting for Emma concerns are discussed regarding domestic abuse and lack of engagement. Social care share that a pre-birth meeting is to be held and that a mother and baby foster placement is to be proposed. This would have been an opportunity to discuss to bring Logan, as an unborn, into the existing proceedings. There is no consideration of commencing a formal pre-birth assessment, as would be expected for a sibling of a child in pre-proceedings.

5.31. Nicole tells the midwife she is feeling low in mood but does not want to take medication, she is advised to refer herself to 'Let's Talk'. Throughout March, Nicole does not attend her antenatal appointments. The social worker completes a core assessment with a plan for Nicole to enter a mother and baby fostering placement under a section 20 agreement when the baby is born. However, this decision should not have been made without a strategy discussion and legal planning. Given the final Review Child Protection Conference is already planned for Emma for de-planning, an unborn Initial Child Protection Conference should have been joined to it, to consider whether the unborn should also be subject to a plan.

5.32. In May, a month before Logan's expected date of delivery, a legal planning meeting is requested. As Nicole is said to be co-operating with a plan for a mother and baby placement it is suggested that commencing to pre-proceedings is the most appropriate route for the expected baby with a plan to issue proceedings following their birth. However, it would be expected practice to bring Logan into the existing proceedings for Emma.

5.33. Nicole attends her maternity appointments and signs up to another emotional wellbeing course via the Children's Centre, she attends four sessions the last being the end of May. The maternity unit receives a call from a concerned family friend who states they have witnessed Nicole smoking cannabis and drinking heavily, Nicole denies this and says her depression is under control without antidepressants. There is a legal planning meeting held two weeks before Logan's due date and legal advice given that the threshold is met and that pre-proceedings is appropriate with a plan of a mother and baby placement. This would have been an opportunity to seek hair strand testing to check whether Nicole really is abstinent of all substances.

June 2015 – March 2016 – birth of Logan to end of first Child Protection Plan

5.34. Nicole attends all antenatal appointments prior to the birth. Logan is born and Nicole is admitted to the postnatal ward. However, the following day she is transferred to hospital via ambulance and admitted to the High Dependency Unit with postnatal sepsis. The following day

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there are concerns noted that overnight Nicole is not engaging well and demanding that Logan be taken away as he would not settle, and Nicole was not responding to his needs. Given the traumatic experience for Nicole around his birth, it is not clear if consideration is given as to whether this was due to her being unwell or was seen as an indication that Nicole is experiencing an early attachment difficulty that needed support.

5.35. There are no other concerns noted while in hospital and a discharge planning meeting takes place. Eight days after his birth, Nicole and Logan are discharged from hospital to the mother and baby foster placement under a voluntary section 20 agreement. The following day the first pre-proceedings meeting is held for Logan with agreement to continue in the residential placement and a hair strand drug test to be commissioned by Legal services. The decision not to join Logan to the care proceedings for Emma is unusual. Care proceedings would normally be issued in respect to baby at birth where there are already care proceedings in respect of their sibling. Although Nicole is said to be cooperating it is not usually advisable to subject a family to a dual process of care and pre-proceedings simultaneously. This meant their needs were not considered together, nor was Nicole assessed within the proceedings as a potential carer for both children.

5.36. Nicole is visited in the foster placement by the midwives until day 21 which is significantly longer than usual and above expected practice before discharge to the health visiting service. Throughout July, Nicole was reported to be coping well with caring for Logan by the Community Midwife and that they are well supported in the environment. An Initial Child Protection Plan is held for Logan and he is made subject to a plan under the category of Neglect. The first Looked After Statutory Review is held for Logan and the plan is for Nicole and Logan to remain in the placement while a parenting assessment is undertaken in pre-proceedings. The health visitor makes a six week visit at the foster carer's home who reports Logan cries a lot at night and that she needs to wake Nicole in the night to feed Logan. At the Core Group no concerns are noted regarding this.

5.37. A further pre-proceedings meeting is held in relation to Logan and the consensus is that Nicole is doing well in the placement and therefore pre-proceedings are likely to end. However, the Health Visitor notes on a visit that Nicole is still tired at night and the foster carer is waking and feeding Logan at night. This could be an indication of low mood and there should have been consideration of screening for postnatal depression such as *Whooley Questions for Depression Screening (1997).*

5.38. However, at the next pre-proceedings meeting there is agreement not to pursue the hair strand testing as no further issues have been reported in the previous twelve weeks. This is a missed opportunity to provide absolute clarity regarding Nicole's substance use and to check how honest she was being with workers. The parenting assessment is due shortly, and the social workers are very positive as to Nicole's progress and care of Logan. However, it is surprising that the hair strand testing was not pursued given the extent of the historical substance abuse and the fact that Emma is not in the care of the Mother and care proceedings had only just finalised.

5.39. The Review Child Protection Conference takes place and Logan remains subject to a plan. The second Looked After Statutory Review takes place with the Care Plan for Nicole and Logan to leave the mother and baby placement and into their own accommodation. At a final pre-proceedings meeting there is agreement that the pre-proceedings should end, owing to the

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positive progress made and a positive parenting assessment. Practice appraisal identified that the legal team is reliant on the views expressed by the social work teams and their assessments of risk unless the assessment is viewed by the lawyer. In addition, the assessment was based on the care provided to Logan while in the foster placement and there had been no opportunity to assess how well Nicole will cope once caring for Logan by herself on leaving the placement and solely responsible for his care.

5.40. The Core Group continues to meet monthly and no concerns are raised regarding Logan's care. Nicole and Logan move out of mother and baby foster placement in November, two months later than planned, which is noted to be because of need to wait for suitable housing to become available for them to move to. However, as no accommodation available, they need to move to live temporarily with Nicole's mother. Logan ceases to be a Looked After Child under Section 20 although he remains subject to a Child Protection Plan.

5.41. In February 2016, Nicole attends her GP as she is pregnant and reports that she has reduced her smoking and now only drinking a small amount of alcohol. Nicole attends the GP on two further occasions and is given advice about cessation of smoking and alcohol. Although it is noted that Logan is on a plan there is no discussion regarding care of Logan or the father and whether they are in an ongoing relationship. Nicole sadly suffers a miscarriage the following week and is prescribed anti-depressants for low mood. This is not shared with the social worker or the core group as would be expected given that Logan is subject to a plan.

5.42. There are increasing concerns as the Health visitor considers the house not to be safe for a small child. Nicole is sleeping on sofa and Logan aged nine months is sleeping in a travel cot. Belongings are seen all over the floor, which is a risk as Logan is mobile, also his immunisations are overdue. At the end of March, Nicole attends Minor Injuries with Logan due to a cut on his head. Logan was reported to have fallen off the sofa onto a concrete floor. The doctor examining him felt the injury did not fit with the timeline and explanation provided so they contacted the on-call paediatrician who advises to refer Logan to Children's Social Care and for a safeguarding medical assessment to take place.

5.43. Logan attended a Paediatric Safeguarding Assessment. The examining Paediatrician's opinion was the injury was consistent with the history given but that as a solitary injury it would be useful for someone to look at the floor at home. Logan was otherwise developmentally appropriate and progressing and is thriving although an unrelated medical condition requiring treatment was noted. Despite the check of the home not taking place and a strategy meeting not being held, as required by the *GSCB Bruising and Injuries to Non-Mobile Children,* following a discussion with the social worker Logan is allowed home. It is not clear if this decision had management sign off.

5.44. At the Review Child Protection Conference, a week later, the social worker recommends a further period of child protection planning. The Conference heard about the head injury to Logan in the week leading up to Conference and of the need for a second medical opinion, but somewhat surprisingly the majority view was to step down to a Child in Need Plan. Discussion regarding the head injury was that it had been assessed by the paediatrician as accidental and consistent with the explanation given by Nicole. However, there had not been a strategy discussion and it is not clear if it was considered whether it had been caused through a possible

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lack of supervision. There follows a period of support through a Child in Need plan which is appraised in section 7.

January 2018 – September 2018 – second period of Child Protection Planning for Logan

5.45. On New Year's Day a referral was made to Children's Social Care by the Police following an incident at her home after which Nicole was arrested. Nicole was at home with her new partner and another couple when his former partner arrived at Nicole's house uninvited. An altercation was said to have taken place in the doorway of her house, with the various parties providing different accounts of who was there, what happened and how the other woman was wounded. Nicole denied any participation in the offence and the alleged victim did not engage with the investigation, so no further Police action could be taken.

5.46. Logan was at home during the incident, however when a check was made by the attending Officers it came back that he was unknown despite previously being subject to a Child Protection Plan. Within the custody record, warning markers were added to Nicole's personal record for drug use and mental health problems. Nicole stated she had taken alcohol and cannabis, although caring for Logan at the time, but denied being drug or alcohol dependant. Her new partner at this time had warning markers for domestic abuse and drugs, and his own children were subject to child protection plans. Whilst Nicole may not have known all these facts, concerns were still held that she was involved in this incident and had been drinking alcohol and smoking cannabis while responsible for Logan's care. It is only two months since Nicole is reported to be free of all substances and the Child in Need plan has ended.

5.47. There is unacceptable delay in convening a strategy meeting which, due to the concerns held, should have been held within a maximum of two days. This problematic practice was a known issue at the time and has since been addressed by a redesign of the Multi-Agency Safeguarding Hub (MASH). A decision is made to convene an Initial Child Protection Case Conference and a plan drawn up to safeguard Logan to undertake a risk assessment and development review for Logan as well as assessment and plans for Nicole's substance misuse.

5.48. Logan is again not brought to a Speech and Language Therapy appointment and is discharged from the service for non-engagement. Although the GSCB 'Was Not Brought' Policy was not yet in place, this is problematic, given that Logan is subject to a child protection plan he cannot bring himself and he still has an unmet need. This third missed appointment should have instead resulted in a referral to Children's Social Care for neglect. Logan does however complete his overdue settling in visits and starts at nursery.

5.49. The Conference was held three weeks later and as well as the concerns regarding the incident and substance misuse there are ongoing concerns regarding neglect of Logan's care, health and development needs, and he becomes subject to a Child Protection Plan under the category of Neglect for the second time. The resulting plan is drawn directly from the issues as set out at the conference and includes expectations that Nicole will seek support for her cannabis misuse, undertake work to explore the impact of her behaviour and Logan's exposure to this, Logan to be taken to all health appointments, with referrals to help better understand his needs e.g. speech and language, and Logan to live in a warm, nurturing and protective environment.

5.50. Legal advice was also to be sought if the plan was not progressed. However, as identified through the practitioners' contribution had the continuing and repeating picture of neglect

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been recognised as a sign of chronic neglect, instead of starting over, a legal planning meeting held then could have considered if the threshold for pre-proceedings was met and secured the necessary improvements.

5.51. It is not clear whether the new partner highlighted in the incident was still in the picture and in contact with Nicole and Logan which given their history would urgently need to be assessed. It is not known whether there was consideration of this within the conference. As the plan does not include requirements to notify the social worker of anyone spending time in the family home so they could be Police checked. It could be assumed that this relationship is known to have ended and Nicole was focussing her efforts on Logan. Alternatively, it may be that it was not considered within the conference whether Nicole's relationship choices may bring Logan into contact with unknown or unassessed people and therefore this was not part of the plan.

5.52. By the time of the Review Conference in April 2018, confirmation had been received from the Police that no further action is being taken against Nicole due to the victim failing to cooperate with the investigation and Nicole had consistently maintained her innocence. There is said to be some progress with the plan as Logan has been taken for his planned operation and several practical tasks relating to conditions in the home had been progressed. However, Logan had not been taken for three health appointments including his audiology appointment. Nicole had not engaged with the home safety team. The social work report for Logan recommends ceasing the Plan, however the Conference rightly decides Logan should remain subject to a Plan to ensure changes are sustained.

5.53. The core group continued to meet monthly and was well attended by a range of professionals. The plan has a focus on securing practical support to address issues with the home conditions. Nicole was tasked to resolve outstanding repairs to the house through accessing support from home safety team however, she is not home for arranged appointments. Concerns remain regarding Logan's significant developmental delay as his language was delayed and he was extremely boisterous and physical with visitors. There are concerns about the management of his behaviour as he is noted to jump off furniture, run at visitors and to punch, kick and pull hair to the extent that he is added to a list of 'dangerous patients'. Housing staff refuse to complete repairs on one occasion due to Logan running off with tools and hitting a workman in their genitals. This unsafe behaviour was not challenged or responded to by Nicole. The need to arrange repairs is noted at core group however, the lack of response to the behaviour by Nicole is not shared. Arrangements were put in place to assess Logan's social, emotional and communication needs.

5.54. There continues to be concerns raised within health agencies regarding Logan presenting with significant developmental delay, regular injuries that could be an indication of a lack of supervision, poor home conditions and outstanding appointments with Speech Therapy, Occupational therapy, Audiology and Dental services. However, this does not appear discussed in the core group and Nicole is said to be engaging well with the Child Protection Plan and the social worker was reporting Nicole '*was doing well and demonstrating good enough parenting*'.

5.55. The risk to Logan was judged to be low as there was, '*no evidence of significant harm*' to Logan. So that in social work supervision their plan was to '*step down*' to a Child in Need Plan at the Review Conference in October. This was despite there being continued concerns such as Logan not being brought to his initial assessment appointment at the complex autism service in

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September. Nicole rang later in the day suggesting she needed a later appointment time and sought to rearrange the appointment. However, it was not able to be rearranged immediately and took place three months later.

September 2018 – January 2019: Child Protection Logan and single assessment for unborn Liam

5.56. In September Nicole advises nursery she is newly pregnant with Liam and they inform Children's Social Care in line with expected practice. Nicole attended a pre maternity pre-booking with the midwife where existing vulnerability of previous cannabis use and maternal mental health needs were identified, and Nicole denied any Domestic abuse. It is not clear whether Nicole was seen alone when asked this question. Nicole did not disclose the name of the father of the unborn baby or whether she was in a continuing relationship. It is not known whether Nicole was asked about this and while there is an expectation to make enquiry about domestic abuse several times in different ways, there is no similar expectation regarding fathers.

5.57. This reflects the previous history regarding '*hidden men*' when Emma was subject to a Child Protection Plan in 2014 and when newly pregnant with Logan. The findings from research such as *Brandon et al (2014)* and in local Serious Case Reviews such as *GSCB 'Lucy'* and *GSCB 'James'* highlight the possible risks from unknown and *unassessed* men in the home. This pregnancy suggested that there was potentially an unknown person having contact with Logan or even undertaking care of him. Even if Logan were not a child with complex needs, who is already known not to cope well with any change to his routine or new people, it would appear vital that this information was explored, shared and assessed.

5.58. Nicole saw her GP suffering from severe morning sickness, and she attended a routine maternity booking appointment. She advised that although she previously used cannabis she had stopped and abstained from alcohol on realising she was pregnant she is however, smoking five cigarettes per day. At her next maternity appointment, she is referred to a smoking cessation clinic and the perinatal mental health form is completed due to previous depression. However, this is not shared with the Perinatal Mental Health Team, so she was not screened by them. *This aspect has resulted in a recommendation in the maternity service IMR.* The midwife made a referral to Children's Social Care in line with expected practice at 12 weeks.

5.59. At the Review Child Protection Case Conference in October it is decided that Logan should continue to be subject to a Child Protection Plan as there were concerns regarding the additional parenting pressure this would bring and Nicole's ability to manage the needs of both Logan and the new baby. At the conference there was evidence that Nicole was not complying with the plan fully as Logan was not being brought to many appointments nor had the home safety check taken place. It may have been prudent for consideration to be given to requesting a Police check of anyone currently in significant contact with Logan or wishing to care for the unborn baby.

5.60. The single assessment for the unborn concluded in December with a recommendation that a Pre-Birth Child Protection Conference should be convened to coincide with the Review Case Conference for Logan which was said to be planned for February 2019. However, this was in fact in April 2019 (in line with the expected interval for review conferences) and this appears to be a simple oversight, as it was a core group was instead planned for February 2019.

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5.61. When making their referral the midwife said there were no concerns in relation to the pregnancy. The social workers involved with Logan and the unborn made unannounced visits and they did not witness Nicole to be under the influence of cannabis nor see the presence of cannabis or apparatus to smoke it in the home. They also understood that the midwife had completed an exhaled carbon monoxide detection test and the result was negative and showed Nicole had not smoked in the previous 24 hours. However, there was still ongoing evidence of neglect as Logan was not being brought to appointments and had suffered repeated minor injuries that may have be attributed to a lack of supervision and for reasons other than cannabis use.

5.62. The assessment appeared to focus on the '*close and nurturing relationship*' apparent between Logan and Nicole and her being '*patient and resilient'* in the light of Logan's challenging behaviours and her perceived engagement with the plan. While relationship-based practice can be highly effective in engaging parents it can also lead to professional over optimism as seen in other GSCB Serious Case Reviews such as '*James*'. While Nicole was clearly devoted to Logan, it did not appear that there were adequate checks made regarding how that devotion was translated into meeting his complex and multiple needs on a daily and sustained basis.

5.63. Therefore, with the additional pressures placed on Nicole, by now three months pregnant, there was no consideration as to whether legal planning or pre-proceedings work should be commenced. Practitioners contribution to the review highlighted that on reflection there was a focus on '*small or minimal improvements*' that did not necessarily mean that Logan's needs were being met nor that there was still unmet need and a level of risk present. Practitioners reflected that in hindsight this may be evidence of feigned compliance as while Nicole agreed that tasks in the plan needed to happen, and reassured they were in progress, they were often not concluded.

January 2019 – May 2019: Child Protection for Logan and legal planning for unborn Liam

5.64. Throughout the coming months the practitioners continued to progress their identified tasks to support and encourage Nicole to meet the requirements of the plan. Although there were still several appointments that were not attended or rearranged by Nicole at very short notice it appears that practitioners felt Nicole was engaging well. However, positively Logan was seen on the second appointment offered by the clinical psychologist, a speech and language therapist and a member of the Early Years Team. A post assessment multi-agency meeting was held to discuss Logan, which included the social workers for both Logan and unborn Liam, and it was a good example of multi-agency liaison and information sharing.

5.65. There was information of concern within the assessment around co-sleeping, sensory seeking behaviours, a lack of response from Nicole when Logan was placing himself in danger and unreal expectations of Logan. For instance, during the assessment he was reported to be able to make toast but of having no road sense, which are not age appropriate expectations for any 3-year-old. The assessment showed Logan was able to adapt his behaviour with the right reassurance, feedback and consistency and identified a set of needs in how best to support Logan. It was concluded that Logan was presenting with a likely attachment disorder, with features of social communication difficulties.

5.66. In January 2019 concerns were referred to Children's Social Care regarding Nicole smoking cannabis and drinking alcohol during her pregnancy. In February nursery refer concerns to the

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social worker that while Nicole did not appear to be under the influence, she smelled of cannabis when she collected Logan. The core group for Logan is held, and the concerns were said to be unsubstantiated and Nicole continue to insist she had ceased all cannabis use. The plan for Logan therefore remained the same, whether this was because it was not sufficiently challenged is not known. However, this would have been an opportunity for the social worker and midwife to arrange drug testing and to refer Nicole to substance misuse services for support.

5.67. Nicole disagreed with the diagnosis of attachment disorder as she believed that Logan did have an Autistic Spectrum Disorder, which can present similarly. Despite this she agreed to attend a Challenging Behaviours Parenting Course and engaged with practitioners. She was supported to raise her concerns regarding the diagnosis by Logan's social worker and Advisory Teacher. The clinical psychologist agreed to review the diagnosis and further assessment took place at home. The assessment outcome remained unchanged but noted that Logan would need a period of intensive support around his emotions and the ability to feel secure with the adults around him.

5.68. A strategy discussion was held by the MASH in late March, the Police reviewer notes the referral is quite specific as it states that Nicole is struggling to meet the needs of Logan which are described as complex, and that the arrival of a new born baby will be difficult for her to manage as a single parent. Nicole is still suspected to be smoking cannabis and the house is messy and dirty. Logan is said to present as having an attachment disorder and can be aggressive and unpredictable. It is agreed that the unborn should be considered at the Review Child Protection Conference for Logan. While the referral is in relation to unborn Liam, the plan for Logan is not being met and there is no consideration of legal planning for Logan as per previous agreed contingency planning.

5.69. At the beginning of April, the health visitor referred concerns about the strong smell of cannabis in the home. Logan was '*still in night clothes and wearing a dirty, heavy nappy*'. Logan was observed to hit Nicole and pull her face and she was said not to react. The home is described as untidy and dirty with old food and wet nappies visible and unsafe, as a TV is still lent against the wall which Logan could access. Nicole denied smoking cannabis, and in response to the concern of the health visitor she claimed the smell was being blown into the house from her neighbours.

5.70. Five days later as a result of the referral from the health visitor a strategy discussion is held. The social worker reported that she had never found any evidence of cannabis misuse despite often making planned and unannounced visits and observed a loving and positive relationship between Nicole and Logan. It was acknowledged that some health appointments were missed or rearranged at short notice but that generally Nicole was keeping on top of appointments. The concerns regarding cannabis use were also discounted as Nicole had attended nursery with Logan the same day with no outward signs of being under the influence and no smell of cannabis detected on her.

5.71. The risk analysis summarises that Logan is very loving towards Nicole but that she '*lacks consistent foresight in order to manage Logan's unpredictable behaviour*'. It is reported that Mum has good engagement with the midwife and nursery, and there is big improvement in his behaviour there with much less lashing out and Nicole is proactively engaging with them. The health visitor debates whether there has been any improvement in Nicole's parenting for over two years. This is discounted, and the improved behaviour in nursery is suggested by the social

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worker to be an indication of a response to consistency and focused parenting. The difference in professional perspective regarding parenting capability is acknowledged, although not escalated and the outcome is for a parenting assessment to be completed.

5.72. The plan continues and in addition to necessary practical support to clear the garden and liaison with the District Council to get the necessary home repairs completed, Children's Services funded additional time for Logan at nursery and Nicole accepted support from a Family Support Worker. The Review Conference for Logan was held and agreed the continuation of his Child Protection Plan under the category of Neglect. The parenting assessment had not yet started.

5.73. There were still professional differences of opinion regarding Nicole's parenting capability. The resulting plan agrees that '*A Safety Plan is to be developed focussing on protecting unborn from Logan's violent behaviour's at* home' and the plan is clear the discharge planning meeting should happen before Nicole and the baby return home. However, there was no escalation or formal challenge that the Child Protection Plan in place for Logan had not yet secured positive and sustained change for Logan and the focus appeared to be on keeping the baby safe from Logan's challenging behaviours with support to continue to prepare for the birth of Liam.

5.74. The Core Group was then held nineteen days after the Review Child Protection Conference, as this was the first core group meeting for Liam, it should have been held within ten working days of his Initial Child Protection Conference and chaired by a team manager in accordance with the GSCB procedures. However, it was not held within required timescales and was chaired by a social worker who was not the allocated social worker. This concern is not just about ensuring procedural compliance, it is because it vitally important that this meeting was held promptly and chaired appropriately as Liam's due date was now only a week away and a robust written safeguarding plan for birth and discharge plan was not yet in place.

5.75. The core group appropriately discussed the need to clear rubbish in the home, although how practically this could be achieved given that the birth was due in only nine days is not clear. The plan for Logan during the birth, when he was to attend nursery as well as his Speech and Language Therapy and Education Health and Care Plan were also discussed. It was agreed that '*Logan will visit Nicole during the day at the hospital and he will be given a tour*' at the weekend so that he was familiar with it as Nicole was due to stay in hospital for two to three days. However, it does not appear that any contingency was discussed or agreed given the proximity of the expected date of delivery and should Liam be born sooner, and Liam was born before the visit could take place.

May 2019 - June 2019: Discharge Planning for Liam, Child Protection Planning for both siblings

5.76. Liam was born four days later, and Logan stayed with his maternal grandmother until Nicole was discharged with Liam on day two and Logan also returned home. A discharge planning meeting took place at Nicole's home the day after their discharge. This was not expected practice.

5.77. The practitioners continued to monitor through routine visits how well Nicole would or could parent both children together. The Core Group is held at the family home two weeks after Liam's birth. Nicole is reported to be doing well coping with both children and bonding well with Liam. While safer sleeping advice was given to Nicole by midwives during the pregnancy, it was not discussed at the meeting. During the meeting Logan was observed to be throwing items that were hitting Nicole and hit Liam on the head. Nicole was reported to have responded

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appropriately to this, reminding him of 'kind hands' and placed him in 'time out' on the stair for an appropriate amount of time. The following day on the advice of the health visitor Nicole took Liam to the GP and was reassured that Liam was unharmed.

5.78. As a result of this event, the health visitor escalated her concerns under Stage 1 of the GSCB Escalation Protocol and asked for a strategy meeting to be convened. This request was discussed by the Children Social Care Team Manager with the Police Decision Maker who decided that the threshold for significant harm was not met as Nicole had responded appropriately. Instead a professionals meeting to share concerns was convened the following week. However, while a social work visit takes place with Nicole that morning to agree the schedule for the parenting assessment, the social worker had to attend court on another matter and the professionals meeting does not take place. The following day the social worker makes contacts by email advising agencies of this and rearranges the professionals meeting for 7th June 2019. The health visitor unaware of this used the Escalation Procedure to highlight her concerns for Liam and Logan and to seek the support required to keep them safe.

5.79. The social worker visited the family the following week and found that Liam was asleep on the sofa and Logan was asleep in his bed upstairs. The social worker found Nicole to be '*very tired, a little incoherent'* from having just woken up. Nicole said that Logan was staying awake a lot at night, and she had started to sleep with Liam on the sofa as it was easier to feed him and stopped her from falling asleep. The social worker advised Nicole that this was not a good idea. This challenge to Nicole regarding the unsafe sleeping arrangement was a good first step, a step further may have been to discuss the concern with the health visitor to agree a joint plan of support for Nicole to ensure she complied with safe sleeping advice and techniques and the consequences, including possible legal planning if she failed to do so.

5.80. The planned reconvened professionals meeting did not take place as the news of Liam's sad death meant that a child death multi-agency response meeting and strategy meeting took place instead. Children's Social Care visited the family home and put in place arrangements for 24-hour daily support for Nicole and Logan within the family home.

5.81. Appraisal of child protection planning shows that Logan was placed on a Child Protection plan twice, firstly between July 2015 and March 2016. Then there were two periods of Logan having support as a child in need due to further concerns being reported. The first period being from March 2016 to August 2016 then again from May 2017 to October 2017. The second plan began in February 2018 and continuing beyond the end of this review period in June 2019. Liam was joined into this planning in April 2019. In effect concerns regarding the neglect of Logan's health needs, the physical living environment, experience of emotional neglect and risks due to exposure to cannabis use and other lifestyle changes were cyclical across this time, with small improvements that were not sustained.

5.82. While there was much commendable effort and individual input by practitioners into the child protection planning and processes this did not always result in Logan's needs being met or an improvement in his lived experience. It is notable that across these periods of time there was little evidence of a robust multi-agency recognition, assessment and response to Logan's lived experience of chronic neglect that secured a consistent and sustained improvement in the circumstances in which Logan was living. While Logan's circumstances were reported to have improved for short periods of time and there were no concerns held by Children's Services

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regarding his basis care there were many examples where Logan's needs were not being met in terms of his care, health, development and lived experience.

5.83. Child protection planning in this period can be seen to have had some limitations. This is further referenced in Section 6 regarding the effectiveness of recognising, and strategy planning for neglect. Pre-birth planning was of particular concern during all three of Nicole's pregnancies as pre-birth assessment should have taken place but did not. This is identified as problematic practice as it a feature of multi-agency practice in general locally as identified in other GSCB Serious Case Reviews and audits. In addition, strategy discussions were not always held when then should have been. There were several incidents where they were not held in a timely way that was commensurate with the concerns identified. This is another feature of problematic multi-agency practice for child protection planning that needs to be robustly addressed.

6. Effectiveness of the recognition and strategy planning regarding substance misuse.

6.1. Throughout the period of this review there were episodes of serious concern where Nicole was involved with smoking cannabis and alcohol taking to excess. There was an apparent minimisation of the effects of Nicole's cannabis use had on all of the children and the risks they were exposed to both in terms of the impact on Nicole's parenting capacity as well as the unknown males Nicole associated with throughout the period under review. It is not clear how much consideration was given by agencies to the fact that she possessed a Class B drug as the possession of cannabis is illegal and can carry significant penalties if proved.

6.2. Therefore, many opportunities to assess and respond to Nicole's sustained cannabis use have been missed. The most recent being during her pregnancy with Liam where her denial of cannabis use was taken at face value and despite some reports during her pregnancy that it had been smelt both on her and in the home and the child protection plan having a goal to achieve abstinence. Social workers were also reassured as they did not see evidence of any cannabis use despite making regular planned and unannounced visits.

6.3. During her pregnancy with Liam, the midwife tested her for evidence of smoking, and the reading confirmed that she had not smoked in the previous 24 hours. Midwives took Nicole's responses to questions about substance misuse including alcohol at face value and did not appear to probe further. Therefore, disclosures that she had used cannabis but had stopped in pregnancy did not lead to a referral for substance misuse services or a referral to the Substance Misuse Midwife.

6.4. At this time referrals were routinely made to the Substance misuse Midwife where women disclose a current history of substance misuse, but Nicole had not disclosed any substance misuse and no referral was made. The alcohol screening tool in Nicole's booking proforma when pregnant with Liam was not fully completed which meant that a clear picture of how much she was drinking was not obtained and an appropriate referral was not made.

6.5. With all three pregnancies there were concerns that Nicole was smoking cannabis and drinking alcohol. Later in the pregnancy with Logan there was information shared from an anonymous phone call that Nicole was drinking and smoking cannabis. Nicole also admitted to a problem with heavy drinking, but no referral was made to support services. There were also concerns reported in the pregnancy with Liam that Nicole was smoking cannabis. The adverse impact of substance misuse in pregnancy is well evidenced and using drugs and alcohol can lead to

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multiple health and social problems for both mother and child[5]. The evidence of adverse effects and the impact of these on Nicole's parenting capability should have been sufficient to prompt referrals to Children's Social Care and substance misuse services.

6.6. In February 2017 when Nicole said that she was suffering from depression and anxiety and was self-medicating with cannabis this would have been an ideal opportunity to take proactive action to support her mental health and abstinence. The Initial Child Protection Conference in February 2018 considered Nicole's history of cannabis misuse and her lifestyle and its impact on Logan. However, Nicole maintained that she was abstinent from cannabis, and the focus of the planning turned away from her lifestyle and misuse of cannabis towards providing practical support and ensuring she was supported to parent Logan effectively.

6.7. Therefore, over time Nicole's cannabis use was not fully addressed in the child protection planning for the children. Opportunities to do so presented themselves both through care proceedings for Emma and pre-proceedings for Logan in 2015 and would have provided a greater focus if these proceedings had been joined and subsequently when child protection plans had not been adhered to.

6.8. However, this also needs to be seen in the context of Nicole's lack of honesty over time with practitioners regarding her cannabis use, the support she said was receiving for her mental health and that it was improving. Had practitioners used their professional curiosity and challenge it would have provided further opportunity to seek assessment or testing of aspects of parental health and wellbeing that are known to have a detrimental impact on parenting capability and to make referrals to specialist support services in line with the *GSCB Parental Substance Misuse and The Impact On Children and Young People (2015)*. They could also have made compliance with these assessments, testing and service provision a non-negotiable aspect of the child protection plans, together with a clear timescale for achieving abstinence and defined consequences of failure to comply.

6.9. Information shared throughout the period under review shows a consistent picture of suspected cannabis use stretching over several years to recent times, supporting the view this was a long-standing substance misuse problem. While Nicole has since been honest about her use of cannabis, which has since been shown to have reduced, the continued goal is abstinence. There are still many unknowns around this, such as the financial implications, whether the cannabis use occurred directly in the home, how Nicole obtained the cannabis and who this potentially brought the children into contact with and indeed whether other substance or alcohol use were also a factor in the chronic neglect experienced by the children.

6.10. This practice appraisal is supported by information from the focussed conversation held with Nicole who shared that this was an aspect of the current plan that she knew had to be complied with. We spoke about her goal in achieving abstinence now, she advised that it had to be achieved otherwise there was a '*very real chance of losing care of Logan too*'. Nicole also helpfully shared that while she had been previously been told to reduce her cannabis use, she had not sought or taken up support previously to achieve this. However, she also shared she would have been unlikely to access substance misuse services and did not recognise it as a problem as she smoked it outside the home or that it affected her parenting capability. Practitioner clarity regarding expectations and consequences therefore appears to be

[5] Hidden Harm: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/120620/hidden-harm-full.pdf

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fundamental in achieving this and demonstrates that compliance can be enhanced by regular testing to confirm abstinence.

7. The effectiveness of multi-agency working around this family across the time period.

December 2012 – August 2015: Pre-birth up to Special Guardianship Order.

6.1. Throughout the first key practice episode between 2012 and 2014 it appears that practitioners were successfully carrying out their individual tasks and meeting their individual agency role. However, while there is evidence of information sharing and consideration of the need for an effective multi-agency response to safeguard and promote the welfare of Emma this did not appear to translate to timely and authoritative practice to protect her. As highlighted in *NSPCC, All Babies Count 2011*, this needed to be seen in the context of the inherent vulnerability of infants and the overall implications to Emma for her health, development, wellbeing and safety.

6.2. The period immediately prior to Children's Social Care becoming involved with Emma following a Strategy Meeting in November 2013 represents an unacceptable delay to safeguarding Emma from risks that had been clearly apparent for many months. The information that precipitated the strategy discussion held similar concerns to those present when the professionals meeting was held in August. There were many examples of concerns ramping up over time where, given Emma's young age and vulnerability, there should have been a referral and an immediate strategy discussion held in line with statutory guidance[6] and local procedure at the time.

6.3. Opportunities were lost during this whole period under review to take decisive and authoritative action to protect Emma. Management oversight and supervision, although found to be held regularly during this period across agencies, therefore does not appear sufficient to support the authoritative practice required in cases like these where there is significant drift and delay. This finding is reflective of problematic practice found within previous Serious Case Reviews and within the Ofsted inspection report in June 2017 that concluded '*some children are left in unsafe situations for too long*'. This was the situation for Emma during this period.

6.4. When Emma did become the subject of a Child Protection Plan for neglect and emotional harm the child protection process did not seem sufficiently focussed on the risk to Emma as although much practical support was offered to Nicole throughout 2014 this did not appear to result in sustained changes for Emma. Practitioners appeared over optimistic regarding Nicole and Chris's parenting of Emma as, although there were many missed appointments, clear indicators of neglect and concerns about their engagement, she appeared to be developing as expected. However, had they considered the wider picture and her lived experience they may have revised their opinion of the care she was receiving.

6.5. When these concerns grew and intensified this was not considered or recognised as evidence of risk of significant harm. Resulting in Emma continuing to experience neglectful parenting where her needs were not always met, and she lived with daily instability in a tumultuous and unsafe home environment with a high level of parental cannabis misuse and exposure to violence and criminality. Even after her parents' relationship was said to have ended Emma was still exposed to high risk around Chris's lifestyle and to alcohol use and unassessed partners that appeared part of Nicole's life at the time.

[6] Working Together to Safeguard Children (2013)

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7.6. Insufficient regard was paid to the relevance of Nicole and Chris's experiences during childhood as well as their current unstable housing, mental health needs, substance misuse and domestic abuse within their relationship and how they were impacting on their parenting capacity. Despite this there was no legal panning meeting to review the threshold for pre-proceedings throughout this eighteen-month period of concern which represented considerable delay for Emma.

7.7. It is also of concern that in this period and beyond, there was very little evidence that in assessment and planning that Nicole or Chris were considered as children themselves. Nicole was 16 years and 8 months and Chris 16 years and 4 months old when it was first known that she was pregnant with Emma. It was clear at this time that both Nicole and Chris had unmet needs and were themselves exposed to risks around substance misuse, criminality and violence.

7.8. Given that Nicole and Chris were still children and there was clear unmet need and unassessed risks these should have been explored so that a multi-agency plan of intervention and support could be put in place to support their transition to adulthood. Nicole was well supported by youth support regarding her future aspirations, preparing for parenthood and her accommodation options but there was no holistic multi-agency assessment of her own experience of being parented, exposure to adverse childhood experiences and the impact of this on her physical and mental health or her ability to parent her own child. There is still little of substance known regarding her childhood.

7.9. Similarly, while there is reference to securing Chris's engagement, there was no assessment or plan in place to identify or address his own needs and the risks to him and others around his cannabis use, criminality, lifestyle and housing instability and whether there was any prospect he could effectively parent Emma. This was less than expected practice and it would be reasonable to assume that this was a systemic issue reflective of the problematic practice found by Ofsted in 2017. Their report highlighted that since their previous inspection in 2011 '*the quality of services to children and families has now deteriorated significantly*' and found that '*assessments, decision-making and planning for children are poor and frequently adult-focused*'.

7.10. However, it should also be noted that there was some evidence of good practice during this period. There was a wide range of agencies and practitioners providing multi-agency support to Emma and Nicole across a range of needs, these included children centres, early help, domestic abuse, family support, GP practices, health visiting, housing support, maternity services as well as the Police and social care who responded to concerns several times during this period. Information was shared and plans were made to seek to keep Emma from harm. In particular, when it was decided that Emma needed to stay in the care of her great-aunt, there was decisive action to secure this. Her Special Guardians confirmed that in their view that the focus of everyone at this time was clearly to do what was in Emma's best interests rather than what was best for the adults around her.

7.11. The support provided by the Youth Support Team, in particular supported good inter-agency working and outcomes for Nicole over time. They were tenacious in engaging services and supporting Nicole both in terms of preparing her for adulthood but also parenthood. They worked with other services to provide a point of stability in Nicole's otherwise chaotic life and she highlighted during her focussed conversation how they had supported her to '*find herself again*' and to have ambitions for her and her children's future. She also spoke of the positive impact the wider professional group had and the *Freedom Programme* had helped her understand and address the domestic abuse and end her relationship with Chris. Further the

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Targeted Family Support provided was noted as a good source of support for Nicole and she advised this was because they '*knew when to just listen, didn't judge, and they helped find answers to problems.'*

7.12. Appraisal of the effectiveness of multi-agency practice within the three periods of Child Protection Planning is predominately considered within analysis included in the sections above and relevant learning addressed there.

March 2016 – December 2017: Child in Need support

7.13. Logan became a Child in Need following his removal from a Child Protection Plan in March 2016. During this period there are several indicators that Nicole is suffering low mood and Logan is not taken for planned medical appointments. Nicole expresses concerns that Logan is starting to head butt and she is concerned about the reducing professional support.

7.14. Contact was stopped by Emma's Special Guardians as they were concerned that Nicole struggled to manage looking after both children at once and to provide the level of supervision required for both children during contact. Nicole was reported to be upset when she is referred to as '*tummy mummy*' during contact and that she does not think it is believed that she has changed since handing over care of Emma to her Aunt. The Friends and Family Assessment and Support Team and Nicole's Youth Support worker help to mediate and support contact, which was not always attended, or which Nicole arrives late to. There are continued concerns from the health visitor regarding Nicole's perceived lack of parenting capability and self-neglect during this time.

7.15. At the end of October 2016, anonymous concerns were reported via the NSPCC online form alleging that Nicole was misusing cannabis and alcohol, that she had been drunk and unconscious in front of Logan, that she throws balls and at toys at Logan's head and drags him around by his arms. It was alleged that she was taking and dealing drugs. It was claimed that Logan had no sleeping routine and he was awake 2am-7am most nights. Nicole was reportedly drinking alcohol to give herself the courage to meet men she was connecting with online and at her home. These concerns, although not substantiated, were a repeat of those known when Emma was a baby.

7.16. The Social worker who had been working with Nicole previously, visited Nicole to discuss the anonymous referral. She reported observing a very positive relationship between Nicole and Logan and discussed the allegations made. Nicole refuted all allegations and said she believed her recent partner had made malicious allegations. The social worker accepted Nicole's denial of the allegations and decided the concerns were unsubstantiated. However, it does not appear that this provoked her 'professional curiosity' regarding the recent partner, whether they had made the report and whether they coincided with the recent period of support when Nicole was said not to be in a relationship. No further action was taken although it is not evident whether this decision was formally signed off by a manager.

7.17. In February 2017, Nicole's father called Police to her address as he had visited her at home and was unable to raise her and Logan then aged 19 months was with her in the address. Eventually when the Police arrived, she opened the door and stated that she had fallen asleep in the living room and did not hear the banging. Logan was confined to the room by a child gate and could not access the rest of the house. Nicole was described as tearful and said that she had smoked cannabis outside to help get her to sleep. The house smelt of cannabis and there was a power socket off the wall in the living room which posed a danger to Logan. The house was described

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as messy and dirty but not 'really filthy'. Logan was described as clean and well cared for, but the environment raised concerns. Advice was given by the attending officer regarding seeking a GP appointment and a referral to Turning Point, Children's Social Care were advised of the incident.

7.18. In March 2017, the single assessment was allocated to a student social worker and undertaken under the supervision of the Deputy Team Manager. This was surprising given the level of concern and previous history of child protection concerns. However, as stated above this should have resulted in a Child Protection Conference being convened to discuss and agree the concerns in a multi-agency forum. It was suggested that the reason for this was there were a high number of children on Child Protection Plans and there was an organisational push to refocus working with families through Child in Need plans instead. It was also noted in the Ofsted inspection that there was a culture where professional challenge was stifled and '*where more work is required to create a culture of interagency challenge*'.

7.19. The student social worker visited, and Nicole was observed to be attentive to Logan and showed him affection. The house was said to be tidy, and Logan's bedroom was a bit messy but of no concern. Whilst the social worker had no concerns in relation to the basic care of Logan, they positively identified concerns regarding the lack of stimulus and limited social engagement and that this could potentially impact his intellectual development through lack of wider world experiences. On several visits Nicole and Logan were observed to be in their pyjamas, and there was concern that social interactions, such as playing at the park, were infrequent.

7.20. The health visitor was contacted by the student social worker regarding the single assessment that was being undertaken as together with concerns regarding Nicole's cannabis use, Logan was presenting with behaviours that are challenging and speech delay. This would have been an ideal opportunity for a period of joint working that included a health needs assessment and assessment of her cannabis use with a plan and appropriate referrals to support her to become abstinent.

7.21. The following month, there is telephone liaison between the student social worker and Health Visitor regarding Nicole not engaging with Children's Social Care. There was significant evidence that Logan's health needs are not being met. Practice appraisal suggests that this should have led to a Health Needs Assessment and an escalation of professional concern about the drift and delay by social care in acting on the evidence available to them and to request a strategy discussion.

7.22. During the assessment when Nicole is seen by the social worker, she advised she had been diagnosed with both anxiety and depression. When asked about medication she said that she did not take the medication prescribed by the doctor as she did not like to take tablets, due to a previous overdose. Nicole was reported to be upset that she was not in contact with Emma and was unsure why this was being refused and this was affecting her emotional state. It is not known whether information was given to Nicole about seeking legal advice or further support from FFAST regarding re-establishing contact for herself and Logan with Emma.

7.23. Nicole had not seen the doctor about her depression since May 2016, and she had missed three further appointments booked with him from January 2017 onwards. There was no lateral check of this by the social worker with the GP surgery, nor was information shared or referred by them, possibly as they were with different GPs. Logan was also not brought to three appointments to discuss a referral for a known medical condition that required treatment.

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Logan was known to have been subject to a Child Protection Plan and a Child in Need the previous year. At the time, the practice's policy was to discuss children who were not brought and missed appointments at the practice safeguarding meetings. Logan was therefore discussed at two practice safeguarding meeting during this period. Although at this time there were no notes made of the discussion and no actions from these meetings documented. It is therefore not clear how and if this information was shared with the assessing social worker.

7.24. Nicole stated she was smoking cannabis every day to help with her mental health. It was reported that during social work visits that the house smelt of cannabis. Nicole assured the student social worker that she had reduced her use and that she did not smoke around Logan. The student social worker recognised that the presence of the smell of cannabis in the house contradicted Nicole's assurance. The risks to Logan's wellbeing were emphasised to Nicole and that she had to stop smoking cannabis completely. Helpfully as part of the assessment Nicole was asked to arrange a doctor's appointment to discuss her mental health and seek prescription medication.

7.25. Over the next few months, there was a pattern of Nicole not bringing Logan to planned health appointments, including the rescheduled urology appointment and missing some appointments for herself. Concerns regarding Logan's behaviour and reports of him injuring himself through play continue as on a home visit by the health visitor, he is observed to have a bruise between his eyes and over the bridge of his nose. This is said by Nicole to have been caused by him falling on to a toy while playing as well as a scratch to his leg from when out walking.

7.26. The Health Visitor asks Nicole to take Logan to see the GP tomorrow and she attends with him three days later. The GP accepts the explanation given and discounts non-accidental injury. Logan was also not brought for his Speech and Language appointment and there appears to be a lack of professional curiosity as to why Nicole, having stated she is concerned about Logan's hearing and delayed speech, does not bring him to these important appointments and to see the Urologist.

7.27. Despite the growing picture of neglect, the social work assessment concludes that Nicole can meet Logan's basic needs. The Community Nursery Nurse (CNN) visits Logan and Nicole at home and discussed that Logan's speech difficulties may be affecting his ability to communicate and this is being presented as challenging behaviours or 'tantrums'. The CNN agrees support for Nicole in how to manage this. Nicole advises she is reluctant to take Logan out because of his behaviour. Although Nicole is not at home for the next appointment, when contacted states she is happy with the CNN supporting her with Logan's tantrums and sleep routines.

7.28. However, the following week despite all evidence to the contrary, Nicole declines the support as '*all has now improved with Logan'*. A child in need meeting is held, and concerns shared that Nicole had not registered Logan for nursery, nor taken him to Speech and Language appointments and had declined further CNN support. It is reported that Nicole is on medication for depression and anxiety and to aid sleep. However, there is no check that she has seen the GP, as there are no appointments recorded in the GP record, this would have enabled practitioners to challenge Nicole on this.

7.29. In May 2017 it was also agreed the Family Support Worker would follow up seeking contact with Emma under the child in need support arrangements. However, this work does not appear to have progressed, as the arrangements proposed were not felt by the Special Guardians to be in Emma's best interests. In June 2017, a further period of multi-agency involvement for Emma

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began in terms of supporting her transition to reception class at school. At the meeting concerns were discussed that Emma may have an attachment disorder, as a result the school arranged an Educational Psychologist appointment. It does not appear that any linkage was made between Emma's presentation and Logan who is presenting very similarly to Emma when the same age.

7.30. The health visitor continues to attempt to visit regularly in July 2017 without gaining access. At the end of July 2017, they gain access to the home and discuss with Nicole the need to attend urology, audiology and speech and language appointments. Nicole agrees to bring Logan to these appointments. However, in August there are further appointments where Logan is not brought, or Nicole does not attend for herself. At the end of August, Logan attends his first speech and language appointment and is said to have expressive and receptive language delay.

7.31. In October 2017, Logan was referred by the health visitor into the social and communication pathway following the outcome of the Ages and Stages Questionnaire (ASQ) development assessment, which highlighted significant social and communication developmental delay. There is no engagement from Nicole with the Speech and Language appointments, a crucial element of the social and communication pathway. This combined with no access visits for the health visitor and Community Nursery Nurse support visits together with missed audiology appointments should have triggered an escalation of concerns to children's social care and is a further example of unacceptable drift and delay for Logan.

7.32. Throughout this period there were regular visits by Children's Services and the work with Nicole and Logan was undertaken mainly by a Family Support Worker. This focussed on practical support to set up home, supporting nursery arrangements for Logan, attending health appointments, liaison with other agencies. It was reported that Nicole had engaged well with this work. At the end of October, the Child in Need support is ceased, and Logan is said to be receiving speech and language therapy and attending nursery and medical appointments. In fact, Logan is not attending his settling in appointments at nursery and there are missed health appointments. It is also said '*Nicole is free of all substance misuse*'. However, this is based on Nicole's self-reporting rather than any testing for its presence. It is agreed that the Children's Centre will continue to provide support and Logan's ongoing needs will be assessed by the nursery and health visitor.

7.33. Even without the benefit of hindsight, this decision appears overly optimistic based on the circumstances of Logan's lived experience at time. As while some aspects of the plan had been achieved, such as registering Logan at nursery and attending one out of the eight planned health appointments there is no evidence how or if it will be sustained. Nicole's abstinence from cannabis and her improving mental health is self-reported. Nicole had shared how her depression and anxiety affected her sleep and mood but there had been no assessment of its impact on her parenting capacity and the neglect of Logan.

7.34. There was no evidence that Nicole was seeking support for her mental health or that it was improving as any progress was self-reported. Additionally, Nicole recently raised fresh concerns regarding Logan exhibiting traits of autism. These would have presented considerable challenges for her as his sole carer and would have likely been exhausting to manage, even if she were not already suffering from low mood. However, this finding is not to criticise the individual practice within this key practice episode but in recognition that there were issues of failing to recognise chronic neglect and the insidious nature of long term, low level neglect as significantly harmful across multi-agency practice in general.

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7.35. Of particular note during this period is February 2017, when Nicole was found to be asleep while caring for Logan and could not be roused by her father when he visited her home. Despite the risks to Logan in these circumstances given her confirmation of cannabis and poor mental health there was no strategy discussion held. Instead it was agreed by the team manager that a single assessment would be undertaken. The outcome of their referral was not shared with the Police, nor was this sought and although they do not case hold, it is an expectation that referrers seek the outcome of the referral if it is not provided to them by children's social care. Given the concerns were a clear indication of ongoing parental neglect and poor supervision, had a strategy meeting taken place with the benefit of all agency information, the threshold for section 47 enquiries was likely to have been met and for an Initial Child Protection Conference to be held.

January 2018 – December 2018: Concerns re multi-agency response

7.36. In January 2018, The Health Visitor raised concerns that Logan's developmental needs were not being met by Nicole and that he was present during a violent incident between her and a third party. Logan had also not been taken to medical appointments. The Health Visitor contacted the social worker to ask about a strategy discussion date on two occasions and was advised that a strategy meeting would be called soon. However, this does not happen and there is no escalation of this by the Health Visitor to their manager or other action taken at this point, this is likely due to the lack of an escalation policy. However, a strategy discussion took place in February 2018.

7.37. In January 2018 support was provided to Emma for provision of Theraplay through the Adoption Support Fund. Despite evidence of ongoing requests by the Special Guardians for information and support with life story work for Emma there is no evidence of any work being undertaken with Emma or of a life story book being prepared for her. While it is not known if this is an issue for practice in general, it is a concern in this case, especially as Emma no longer has contact with her mother and sibling who are also part of her history, identity and understand of self.

7.38. In April 2018, Emma's special guardians were referred to the Children and Young Peoples Service, 2gether for a parenting programme, and this was diverted to the fostering changes programme due to the Emma' being subject to Special Guardianship. In September 2018, a referral was made by a consultant paediatrician for Emma to consider a diagnosis of Autism Spectrum Disorder. Emma had not previously been referred for assessment through the pre-school pathway. The referral noted that on assessments conducted so far, Emma had scored equally high for both attachment disorder and ASD. Emma was experiencing complex social and emotional difficulties, challenging episodes of behaviour, problems attending school and sleep difficulties.

7.39. In September 2018, FFAST liaised with the Guardians regarding setting up letterbox contact with Emma maternal grandfather and they declined a request from him to reopen face to face contact as they felt his would impact Emma being settled. He was informed of his right to seek Legal Advice about seeking court awarded contact. However, it is also incredibly disappointing that contact for Logan to maintain a sibling relationship with Emma ended in 2016. This was despite attempts to mediate it by FFAST and Youth Support there has been no contact between the siblings since.

7.40. The records indicate that Nicole was given advice about how to seek contact with Emma through the courts but not given any support to do so. It seems worrying that although Nicole

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still had parental responsibility for Emma, it appears she was not aware of this until very recently and therefore felt prohibited from attempting to renewing contact with Emma for herself or Logan. While it is well understood that Special Guardians have over riding parental responsibility for all aspects of caring for the child and for taking the decisions to do with their upbringing, the local authority should have been more proactive in preserving the basic link between the child and their birth family[7] and supporting a positive renewal of contact with Emma if at all possible.

7.41. Emma was seen for assessment by the CYPS clinical psychologist in November and the outcome of the initial assessment suggested Emma' difficulties were most likely due to early trauma and not ASD. Further assessment was scheduled using specific Autistic Spectrum Disorder assessment tools (ADOS). An application was also made in December 2018 to the Adoption Support Fund for Dyadic Developmental Psychotherapy[8] to be provided for Emma and her Guardians.

7.42. The clinical psychologists met with Emma' Guardians the following week to discuss the findings of the assessment. The clinical opinion was that Emma' presentation was consistent with significant early trauma and not with Autistic Spectrum Disorder. The Guardians agreed with the assessment outcome and a plan to continue with the pathway already in place for Dyadic Developmental Psychotherapy. Information was shared appropriately with FFAST who were supporting applications for Emma through the Adoption Support Fund and with the school regarding the outcome of the assessment. There was evidence of good multi-agency liaison in this episode.

7.43. In effect during this period there were many individual practitioners working dedicatedly on their aspects of the plan to seek the best outcomes for Logan and resolve practical concerns such as the repairs required within the home and clearing of a previous tenant's rubbish from the garden. These outcomes were said to have taken a considerable amount of time and effort to facilitate. There was also a strong commitment from the partners in attend meetings as core groups and conferences which were said to quorate and well attended. Strategy meetings when held, were often delayed and did not always have the right practitioners present as they were often not invited, but those who were prioritised their attendance and contribution to discussions.

7.44. While there was some information sharing outside of these processes there was not sufficient correlation of key episodes within individual agencies or as a multi-agency group and each episode appeared to be dealt with in isolation. The multi-agency response could have been strengthened had the information been triangulated, and supported by a robust and full chronology, which could have resulted in professionally curious conversations, multi-agency assessment and referrals to Children Social Care as appropriate. There appeared to be insufficient recognition that '*Caring for a child with additional needs can increase parents' stress levels and escalate other problems (Baker et al., 2003) and that children with disabilities and health care needs, and younger children are all more likely than others to experience abuse and neglect*'.

[7] Special guardianship guidance, Statutory guidance for local authorities on the Special Guardianship Regulations 2005 (as amended by the Special Guardianship (Amendment) Regulations 2016), Department of Education (January 2017).

[8] Dyadic Developmental Psychotherapy is an attachment theory-based therapy that was developed by Daniel Hughes. It was designed as an intervention for children who have suffered Developmental Trauma.

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7.45. During the period of most recent child protection planning from February 2018 onwards when Logan, and latterly Liam, were subject to a child protection plan the core groups were held regularly and well attended by a core of involved professionals such as social worker, health visitor and Logan's nursery and always included Nicole. There was also involvement from the Advisory Teaching Service and more latterly the midwife and social worker for Liam. However, there was poor involvement of the 2gether Children and Young People's Service due to lack of invitation to core groups and conferences due to an oversight until the case was escalated by them. As their diagnostic assessment was important to understand Logan's behaviour and needs, and as there had been professional disagreement, it would have been helpful for them to have had more involvement and input into discussions and risk analysis in the core groups and conference.

7.46. It was also considered at the analysis event that, although health visiting records show that both Emma and Logan were assessed through Schedule of Growing Skills (SGS) with developmental delay by health visiting, it is not clear what interventions were being offered to the children by agencies or whether these concerns were being discussed within the multi-agency arena. This lack of information sharing could possibly have added to the drift and delay in the management of support to the family.

7.47. For instance, in April 2018 at the Review Child Protection Conference the social worker for Logan recommended ceasing the Plan despite it only being in place for two months and the core group having met twice. This appeared overly optimistic and, at the next Review Conference held in October 2018 similar issues were raised and concerns held. In addition, it is not clear what improvements were made as there were still concerns regarding the conditions in the home, home safety checks had not been cooperated with and there were missed medical appointments. The multi-agency view was that the plan should continue, and the conference outcome was for the Plan is to continue to ensure changes when made are sustained. This is an example of effective multi-agency partnership working.

8. Use of Escalation and challenge of other agencies when the child protection plans were not considered effective.

8.1. As highlighted in the practice appraisal in previous sections there were several occasions identified during the period under review where escalation or professional challenge could or should have been used when child protection plans were considered not to be effective and health professionals were concerned about drift or delay. However, the first recorded use of professional challenge under the *GSCB Escalation of Professional Concerns Guidance (2019)* was in February 2019 the same month as its launch.

8.2. It was recorded that the clinical psychologist who had undertaken the autism assessment of Logan contacted the social worker regarding this. The social worker was reported to disagree about the concerns raised by the clinical psychologist regarding the emotional neglect of Logan and there was an obvious difference of opinion regarding Nicole's parenting capacity. This demonstrated good professional curiosity, respectful uncertainty and challenge. The clinical psychologist concerned that the evidence of neglect was not being recognised, escalated her concerns to her manager who was said to have then progressed the concern to Stage 2 of the protocol and they spoke to social worker's manager.

8.3. The guidance is clear that in resolving professional disputes escalation '*should include the reasons why the practice is unsafe for children, specifically what they would like to change for*

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the child and how it is having an impact on the children'. It is not clear whether this was used as the basis of their conversation and the outcome agreed was to invite a representative from the 2gether team to attend core group and the review conference in April 2019. Which previously had not happened due to an oversight.

8.4. However, this did not resolve their disparate professional opinion regarding why the practice was felt to be unsafe for Logan or that he was believed to be at risk or likelihood of significant harm. This therefore should have been escalated to Stage 3. In addition, as Logan was subject to a Child Protection Plan, the escalation should have been notified to the Independent Reviewing Officer in accordance with the protocol. It is likely that as it is not recorded in the Children's Social Care case records that it was not considered as a formal escalation under the protocol.

8.5. In May 2019 there was escalation by the health visitor regarding her concerns about Liam's physical safety due to Logan hitting him on the head in the core group and then the professional's meeting convened to discuss the difference in professional opinion being postponed. However, despite an expectation that all such escalations are resolved in five days this was not resolved. These disparate opinions had been evident since January 2018 but had not begun to be formalised until early 2019, in the pre-birth period prior to Liam's birth.

8.6. While the escalation was in relation to the physical safety of Liam around Logan due to his unpredictable and aggressive behaviour what would have been more useful would have been escalation in relation to concerns regarding chronic neglect, in relation to further concerns regarding Nicole's continuing misuse of cannabis, the impact of Nicole's own ongoing mental health needs and her parenting capability in managing Logan's complex and challenging behaviours while also caring for Liam as a lone parent without family networks close by. The escalation is reported to have also been recommending consideration of a specialist educational placement for Logan which instead should have been addressed through the Education, Health and Care Plan.

8.7. The Nursery was a member of the Core Group and contributed to the Review Child Protection Conference from April 2018 onwards. One of the factors discussed at the practitioner event was the effectiveness of the core group plan and that it was not always updated or reflective of known or emergent needs. Within practice appraisal it was noted that on reflection staff believed that there was insufficient progress being made in progressing the child protection plan. They felt that the "*same things were being discussed over and again and they could not see the impact of the plan on Logan".* Staff at the nursery believed that the focus of the plan was not on Logan's wider needs but the physical environment he was living in, for example, the home conditions. However, this was not escalated at the time because of a lack of awareness of the GSCB Escalation Protocol and continued culture of low inter-agency challenge.

9. The effectiveness of the recognising, and strategy planning, regarding neglect.

9.1. As highlighted by the analysis in the sections above the recognition, strategy planning and response to aspects of neglect was variable and at times poor across the periods under review. This has previously been identified as problematic practice and a systemic issue by the GCSE safeguarding partners and relevant agencies to be an issue of concern and priority for practice improvement.

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9.2. It is clear in the sections covering practice appraisal of the period from the realisation of pregnancy to Emma becoming subject to a Special Guardianship Order in August 2015 that the professional recognition and response to neglect was less than expected practice and this is commented on in this section. In addition, as the key practice episodes demonstrate there is almost a mirror image picture of chronic but low-level neglect that pervades this case.

9.3. While this review does not set out to further examine or make judgements regarding this, as a context the *Inspection of services for children in need of help and protection, children looked after and care leavers and Review of the effectiveness of the Local Safeguarding Children* by Ofsted published in June 2017, criticised the Children's Social Care response to neglect and the partnership understanding of neglect.

9.4. In particular, Ofsted found that '*Plans are often overly optimistic about the capacity of parents to change or their ability to protect their children, particularly for those children who experience domestic abuse, parental substance misuse or the cumulative impact of neglect'.* This finding is consistent with practice appraisal and analysis in the earlier sections. Since the inspection, as part of the partnership improvement plan, there has been a focus on ensuring a more consistent identification of neglect and providing more effective help at an earlier stage.

9.5. Therefore, the practice appraisal in this section has focussed on more recent practice in this case around neglect and this is explored and analysed below. Throughout the period from Logan's birth in June 2015 to the very end of the review period in June 2019, it is known that practitioners did not always agree regarding the level of physical or emotional neglect he was exposed to. This section seeks to consider and appraise why practitioners observed fluctuating conditions within the home and why different opinions were held regarding whether it was acceptable or safe for Logan to be there. There is also consideration of the disparate views regarding whether Nicole was meeting Logan's emotional needs and if her parenting approach was able to ensure that his emotional needs as well as his physical and developmental needs were met.

Practitioner response to signs of cumulative neglect of the children

9.6. As highlighted in previous sections Logan was subject to a Child Protection Plan for neglect firstly from birth to March 2016 and he was then supported as a Child in Need from March 2017 to October 2017 and then from February 2018 onwards again, subject to a Child Protection Plan. Across these periods of time it appears that concerns were held by a range of professionals including:

- evidence of neglect around conditions in the home such as rubbish, old food left out, dirty nappies, messy home conditions and electric sockets not secured in place
- reported lack of appropriate or consistent response to Logan's challenging, aggressive or overly boisterous behaviour
- Logan was not consistently being brought for his health appointments and attendance was very sporadic despite stated parental concerns
- Nicole not always attending planned health appointments for herself
- Practitioners could not always gain access on planned or unannounced visits
- Nicole was at times not at home when planned visits, e.g. home safety checks when made
- Lack of toys and social activities provided to Logan
- Poor daily living routines e.g. Logan and Nicole still in their nightwear and Logan's nappy not changed when visits were made.

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9.7. The issue of neglect was frequently raised at the GP Practice monthly safeguarding meetings which were attended by the GPs, Practice Nurses, Health Visitors and Midwives. Social workers are invited to these meetings but do not attend as they discuss multiple patients. Logan and Nicole were discussed at meetings frequently, including shortly after registering in April 2016, four times in 2017, ten times in 2018 and three times in the first part of 2019. Actions from each of these meetings along with decisions about who was to progress the actions were recorded, for example discussing the concern about Logan's testicular bruising at the next Core Group Meeting. The fact that they were discussed so frequently was noted as '*a sign of how concerned all the professionals were'*. However, this did not result in a referral to Children's Social Care at any point which could bring into question the usefulness and purpose of these meetings.

9.8. Also, it does not appear that the concerns from health professionals regarding neglectful parenting were viewed in the same way by Children's Social Care or brought into professionally curious conversations. The difference in professional opinion was not always raised at core groups, escalated nor formalised at Child Protection Conferences. There is further comment on this in the section above regarding escalation.

9.9. In addition, there were other aspects that were indicative of neglect that were not always recognised or shared with the practitioners working with the family. For instance, plans were in place for Logan to start nursery in early January 2018 however, he could start until three weeks later as, although Nicole had secured a place earlier in the year, she had not arranged Logan's settling in sessions. These should have been completed by December 2017.

9.10. The reason for this delay should have been explored with Nicole and shared with Children's Social Care to inform the social worker assessment in progress. This would have allowed for consideration of whether additional support may be required to ensure Nicole brought Logan to the settling sessions and commence nursery and considered as part of the assessment of neglect.

9.11. Logan was described by the staff at Nursery as '*funny and boisterous'* and that he liked to play with his toys in the nursery and his key worker had a good relationship with him. There are no reports of Logan sustaining any injury to himself at Nursery. However, their records indicate that there were a significant number of occasions when Logan attended Nursery with marks and bruising. These were always recorded in their notes but not always reported despite Logan being subject to a Child Protection Plan. Nor were they captured on a body map so that when marks or bruises were seen they could be triangulated against those previously noted. The nursery duly catalogued many marks and bruises over a seven-month period as follows.

Date	Event	Outcome
September 2018	Logan presented *"with Large scratch 4 inches left thigh scabbing caught leg on broken plastic chair"*. Also *"Bruise reported at top of (Logan's) nose between eyebrows and right side of hip"*.	Not reported to Children's Social Care, *"no explanation from mother"* as to how this occurred
October 2018	Staff noticed several bruises on the hips, tops of ankles, thighs, knees, lower back and arms. Nursery contacted mum who explained "*Logan was staying with maternal grandparents at the weekend and his 5-year-old aunt had been very rough with him when playing and pushed him"*.	Duty social worker contacted and asked them to ask Nicole. They then said they were '*happy with the explanation*' provided. There was no consideration of a strategy discussion.

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Date	Event	Outcome
November 2018	Logan presented with "*blue green and brown marks on the shins, back, knees and arms. He had been to nans lots of toys and he fell over them*"	The record was signed by Nicole, staff member and manager. Not reported to Children's Social Care.
December 2018	Logan presented "*with a bruise the size of 50p..which is blue and yellow in colour and raised on the left knee mum said he threw himself on the table*"	The record was signed by Nicole, staff member and manager. Not reported to Children's Social Care.
December 2018	Staff at the Nursery noticed a blue mark and swelling on Logan's genital area. The bruise was described '*as the size of a 10 pence piece and a red bruise on upper thigh*'. Mother was contacted and she informed the member of staff that she was unsure how it had happened. Staff advised mother to take Logan to the GP and attempted to contact the social worker multiple times that afternoon. A strategy discussion was not held.	Two days later Nicole had not taken Logan to GP and insisted she make an appointment. Following Health Visitor intervention Logan was seen on the Paediatric Assessment Unit and said not to having bruising and discharged. The records indicate that a social worker informed the Health Visitor that "*she is not worried about the injury as she knows the family*."
December 2018	Staff found several red, scabbed one pence piece sized scratches on the back of Logan's left thigh three inches in length. There were "*blueish bruises on his knee… were raised and swollen*". There were "three *darker bruises on his right knee, one blueish bruise on his left knee which presented as raised and swollen, two bruises on his left thigh area and one darker bruise on his left leg which was the size of one pence piece*". *There were six very thin scratches on the back and top of left leg.* The member of staff contacted the senior manager and Nicole to discuss the injuries.	Nicole told them that Logan had fallen several times on the day before while she was moving furniture and rubbish. The allocated social worker was contacted but there was no answer. They then contacted the Duty social worker and were told that the allocated social worker will "*pick this up in the morning*". There is no record of the outcome of this.
January 2019	During a nappy change, staff member noticed redness and soreness in two places in the genital area as he flinched and whimpered when wiping him during the nappy change. Staff telephoned Nicole and she said that she had not noticed it. The staff member contacted the Area Manager for advice because it was a safeguarding concern. Staff advised Nicole to make a doctor's appointment which she did.	The member of staff contacted the allocated and Duty social worker. The Duty social worker called back and informed them that she had also advised Nicole to make an appointment with her GP. However, under procedure there should have been a strategy discussion. Nicole told staff that the doctor had told her it was nappy rash.
January 2019	Staff noticed that Logan had two small bruises inside of his knee; these were blue in colour and the size of a five pence piece. He had another bruise slightly lower down on his calve and this was slightly bigger in size and brown in colour. Explanation provided by Nicole was that Logan had tried to jump off a chair, Nicole went to grab him, and he bumped his leg on the chair.	Nicole informed the member of staff that she had provided treatment at home. Staff made the decision that this incident did not require her to contact Children's Social Care. The record of the incident was signed by Nicole, the member of staff and the manager.
January 2019	Staff at the Nursery noticed a blue mark on Logan's lower back; there was also a blue mark and a graze on his chest. Nicole informed staff	Staff and the manager at the Nursery were satisfied with this explanation and did not contact Children's Social

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Date	Event	Outcome
	that Logan was jumping around and jumped towards Nicole; she caught him; however, she was not ready for him. He also bumped his back leg. Nicole explained that "*Logan fell on a cup whilst jumping and injured his leg".*	Care. They recorded the incident which was signed by Nicole, member of staff and manager.
February 2019	A member of staff noticed friction burns which were the size of a 20 pence coin on Logan's head. The member of staff was satisfied with the explanation given by Nicole, that Logan rubbed his head on the carpet.	This incident was not reported to Children's Social Care. The record was signed by the manager and Nicole.
March 2019	A member of staff found bruises on Logan's legs and arms; these were large and dark brown in colour. There were large bruises on Logan's knees and lower legs. In addition, there were faint bruises on Logan's arms and one on his left side.	There is no record of making contact with 'Children's Social Care.
March 2019	A member of staff discovered that Logan had a large swollen bruise on bottom of his right shin and a smaller bruise and a scab on both of his ankles. He was brought into the nursery by Nicole who told staff that Logan fell over whilst he was walking.	There is no record of making contact with Children's Social Care. The record was signed by the manager and Nicole.
April 2019	Nursery found Logan had various brown bruises on both knees and shins: *Two brown bruises on the right thigh; One brown bruise of the front of left thigh; One blue bruise on the side of left thigh; Scratches on left knee; Brown bruise on back; Two small bruises on right arm; Scab on right elbow*.	When asked, Nicole informed the member of staff that he had scratched himself after he was '*told off*', and that he also pinched himself and this resulted in the bruising. There is no record of making contact with Children's Social Care.

9.12. Had this chronology been shared with core group at each meeting , it would have helped to build a picture of the pattern, frequency and nature of the injuries to Logan and to understand it in the context of his needs and the care provided to him. It would have also provided important contextual information to the medic assessing Logan on the Paediatric Assessment Unit. This is especially relevant as the *NICE Guidance, When to suspect child maltreatment* (2009, update July 2019) highlights that '*Neglect can be conceptualised as a process involving accumulating risk to the child due to a failure to provide or omission rather than actual incidents of abuse. It is a persistent failure to meet the child's or young person's needs that may or may not be wilful*'.

9.13. However, further consideration of these injuries as a possible pattern of neglect did not happen. Nor were some practitioners aware that neglect does not have to be shown to be wilful for it to constitute risk or likelihood of significant harm. The practitioner contribution highlighted that contributory factors were a lack of awareness or understanding of the GSCB strategy, procedures and toolkit for neglect.

9.14. As highlighted in the summary notes from the practitioners learning event, in their group work discussions the practitioners were insightful and highly reflective regarding why there had been a lack of recognition of marks and bruises as possible indicators of neglect. Their discussions are reflective of NICE guidance which recognises that '*it can be difficult in deciding what is adequate*

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supervision at different ages and stages of cognitive development of the child or young person and therefore the GDG advise the healthcare professional to follow the 'consider' process in this guidance'. Practitioners expressed that they did not and were not sufficiently aware of this aspect of neglect. The GSCB Neglect Strategy, procedures and associated Neglect Toolkit and the GSCE current training does have guidance on this aspect of neglect.

9.15. Practitioners were also not sufficiently alert to how feigned or partial compliance '*is characterised by features that may include deflecting or controlling conversations, for instance telling workers what they want to hear'*. There were many examples of this throughout the entire period under review and of sporadic compliance in '*cooperating just enough so as not to raise suspicions'* and then not attending, cancelling or rescheduling appointments. This can also include active avoidance of home visits, such as being out when workers call and then asking to reschedule. All of which can be indicators of a pattern of neglect and were evident in this case.

9.16. What also needs to be acknowledged is that while procedures and practice toolkits are useful, they cannot replace critical thinking and professional judgement, although they can assist in providing objectivity in benchmarking the care received as well as a child's health and developmental progress. Therefore, further work is required to ensure staff across the partnership are competent in understanding and working with neglect.

Chapter 4 - Findings and lessons learnt with suggested recommendations for the consideration of GSCE

10.1. This chapter outlines the findings and suggested recommendations identified from the analysis of the key events and professional practice. They are produced for the consideration of the GSCE to reflect on and implement any learning from this Serious Case Review. The involvement of practitioners and their managers has been fundamental from the outset of the review, as has the support of the local Serious Case Review Panel. The learning points set out for consideration by the GCSE reflect the collaboration and insight provided through their engagement and support.

10.2. The discussion of the key findings has been arranged around five central and connected themes that seek to inform learning and improvement across the system. Reference is made to the literature, including other local reviews, inspection findings where relevant and to recent developments in improving the response to child neglect, pre-birth assessment and parental substance misuse. There are also findings regarding children with a disability and those subject to legal orders that are incorporated below. In delivering these findings consideration has been given to providing partners with a summary analysis that does not repeat information already being shared in other recent local reviews or as part of the wider work streams.

10.3. The themes identified in this review relate to:

- Understanding and responding to neglect
- Working with feigned and partial compliance
- Pre-birth assessment and discharge planning
- Safer sleeping arrangements
- Voice of the child and lived experience, particularly those with a disability
- Thresholds for intervention and child Protection processes and procedures

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10.4. While all the findings listed are relevant in this case, the identification and response to neglect is central to the learning within this review. The wide-ranging neglect experienced by Emma and its impact on her within the context of early life trauma is well documented. It was also identified that both ongoing emotional and physical neglect also featured within Logan's care and that practitioners in agencies held disparate views regarding the level of physical and emotional neglect of Logan, and that Liam once born, would likely to be subject to the same level of care and have the same lived experience.

Understanding and responding to neglect

10.5. While Children's Social Care and other practitioners were aware of the repeating pattern of neglect, they were not all aware of all the marks, bruising and minor injuries that were observed for Logan. Therefore, when incidents were reported in isolation their consideration and response was based on it being an isolated episode rather than a cumulative chronology over time detailing the number, frequency, type and explanation of these injuries. It was also noted, that on several occasions Nicole was asked to take Logan to the GP, this is not accepted best practice. Therefore when, marks, bruises and injuries were reported to Children's Social Care, the GSCB procedures must be followed and a strategy discussion held to discuss the significance of these injuries. This is known to be an issue in practice in general and has been highlighted in several local Serious Case Reviews such as 'Phillip' and a yet to be published GSCB SCR.

10.6. Whilst children of Logan's age and stage of development usually have some marks or bruising due to play or falls the number of injuries sustained appears to be unusual. This warranted further investigation including strategy discussions and medical assessments. However, this did not happen as the information was not shared in a timely or systematic way. Therefore, many incidents were noted and remained solely on Logan's nursery record. This has been a finding in many national Serious Case Reviews and expected practice in this situation is clearly laid out in statutory guidance. Statutory guidance highlights a barrier to recognising abuse and neglect as '*assumptions that indicators of possible abuse such as behaviour, mood and injury relate to the child's disability without further exploration*'[9] and reflective of problematic practice in this case.

10.7. Practitioners, therefore, did not apply professional curiosity to consider how the explanations for the injuries fitted with what was already known of Logan's presentation at an education setting and when cared for by others. Or considering whether Logan had been observed to inflict injury to himself through pinching and scratching himself on previous occasions. Further, given Logan's complex needs and '*boisterous behaviour*', whether the circumstances of him suffering marks, bruises and scratches so frequently indicated a possible lack of care or supervision and an indication of neglect. It therefore appears that consideration of the observed injuries was in terms of whether they fitted the explanation rather than as a pattern of neglect. They were also reassured by their '*knowing the family*' and their view of '*the close and loving relationship*'. This meant they discounted repeat minor injuries as potential indicators of neglect, which indicates problematic practice that requires improvement.

10.8. In assessing parenting capacity and neglect and whether any improvements were significant or sustainable over time there were many episodes where assessments and decisions were made based on reported improvements but where these improvements had not been tested over time in less supported circumstances. For instance, while Logan and Nicole were in a mother and baby foster placement where the foster carer was said to be caring for Logan at night. Also in the later part of 2018 onwards when Targeted Family Support were involved there was

[9] Keeping Children Safe in Education (2018) – updated September 2019

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significantly improved compliance from Nicole, however she was receiving intensive support to address many practical aspects of the conditions with the home and the challenge is how she would or could sustain this when support was reduced or removed if the underlying issues such as cannabis misuse and poor mental health were not addressed.

10.9. What was also striking within the practice appraisal is that, when working to identify and assess neglect many practitioners held a presumption that they were looking for signs of wilful neglect rather than needing to assess the impact on children of the neglectful they are receiving. Neglect whether wilful or due to other parental factors, is significantly harmful, particularly in pregnancy and infant and early years development. It has been known for many years to potentially have an adverse impact on brain development. However, it is a systemic issue already noted in general practice and this needs further exploration around how practitioners are supported to work with children who have experienced or likely to experience neglect.

Learning point one - Recognition and response to neglect
The multi-agency partnership response to neglect continues to need to be strengthened to ensure practitioners are competent and confident in working with all aspects and types of neglect including assessment of parenting capacity, motivation to change and sustainability of any improvements once services withdraw. Practitioners need to be equipped to recognise possible feigned compliance and to address this in assessment and plans.

Recommendation 1

- The GSCE needs to assure itself that the planned refocus on the GSCB Neglect Strategy, procedures, single agency training and multi-agency training programme results in demonstrable improved outcomes for children living in neglectful circumstances.

Pre-birth assessment and planning

10.10. There was no pre-birth assessment undertaken when Nicole was pregnant with Emma or Logan. Therefore, had a robust pre-birth assessment been completed prior to their birth that included consideration and assessment of Nicole's history this would have supported and informed decision making regarding the possible level of risk and support required.

10.11. Practitioners knew that Nicole was pregnant in September 2018, and the core group meeting held in early October would have been the ideal opportunity to consider the implications for Logan's care and to make plans to undertake a pre-birth assessment. As highlighted by Calder et al (2000), '*if a referral is made at this point, the pre-birth assessment should begin as quickly as possible.*' In December, a management decision was made that Liam, as unborn baby, would be dealt with as a Child in Need, prior to a pre-birth assessment being undertaken and then being joined to the Review Child Protection Conference for Logan in February 2019. However, a pre-birth assessment did not take place, and this was not subject to effective management oversight.

10.12. It is recognised that pregnancy and childbirth can offer a unique window of opportunity for change and there is a wealth of evidence to show that parental difficulties may have a significant impact in pregnancy and on the longer-term health of the child *(Lushey et al., 2018*). The lack of a pre-birth assessment was poor practice as, where the threshold is met for an ongoing role for Children's Services, a Pre-birth Assessment should be undertaken. The procedures highlight '*It is very important that this assessment involves relevant multi-agency professionals directly in the assessment'*. This was not challenged by the practitioners involved

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with Nicole and Logan and might have provided the opportunity to develop a collaborative and cohesive plan for him.

10.13. The approach of joining a Pre-Birth conference to a sibling's Review conference is a provision within the GSCB Pre-birth procedures. The plan to join the Pre-birth conference to the Review conference was said to be made so the conference took place by the 24 weeks. However, the Review conference was not scheduled until April 2019, which was only four weeks from Liam's due date. The conference was not convened once this was realised and this should have happened '*as soon as possible but no later than by week 28 of the pregnancy*'. It is not clear why this did not happen in this case other than it being an error.

10.14. Had the Pre-birth conference taken place within timescales it would have given the multi-agency group a better opportunity to explore and assess the impact of Nicole's social history, use of cannabis and any mental health needs which had been issues in her previous pregnancies. It also would have given more opportunity to consider how Nicole would cope with a new baby given the challenges already faced given Logan's complex needs and plan what additional support might be required. This would have ensured there was a written safeguarding plan in place that was shared and placed on file of all involved practitioners as required by the procedures.

10.15. The delay in holding the meeting was clearly outside of agreed procedure and protocol and should have been challenged and escalated. It would have provided the opportunity for a legal planning meeting and whether there was a need to consider supervised care, such as a mother and baby placement as was in place with Logan. With no pre-birth assessment in place it was not apparent what had changed to suggest that care of Liam would be different given the history of neglectful parenting, known poor mental health and misuse of cannabis perinatally. *Reder and Duncan, 1999* highlight that even where such concerns are historical, it is widely understood *'that there is likelihood of relapse and increased risk to children'* and this should have been considered.

10.16. Liam and Nicole were discharged home from hospital before a discharge planning meeting could take place. Both the Child Protection Plan and the *Gloucestershire Unborn Baby Protocol* were clear that the discharge planning meeting must take place within one day and '*at least 24 hours prior to discharge to allow for appropriate arrangements to be made to support or safeguard the child or young person'*. This was said to be because it was a bank holiday weekend and Nicole was determined to go home. However, there was a clear expectation in the child protection plan that given the concerns around consistent parenting following the birth of both Emma and Logan, the discharge planning meeting was to take place before going home, this was made clear to them.

10.17. It was noted within the maternity information that it is not unusual for children subject to a Plan to be discharged and the meeting to then take place. It was said that the guidance in place at the time was not clear. However, the procedure is very clear on this as it clarifies that '*Where birth has taken place out of hours or at the weekend, then the Emergency Duty Team (EDT) will represent Children's Social Care'*. This is therefore a practice aspect of which the partnership should assure themselves.

10.18. It would appear from records and discussion at the practitioner event that there was an optimism regarding Nicole's ability to parent Liam, as a '*positive, close and nurturing*

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relationship' was described between Nicole and Logan and a view held that Nicole had worked in partnership with the Core Group which provided them with reassurance regarding this. It was also suggested that the lack of effective challenge may have been influenced by the fact that Liam and Nicole had already been discharged home. Any challenge to the current arrangements and may therefore have been perceived as difficult.

10.19. It is apparent from the practice appraisal and analysis that following the birth of both Emma and Logan there were concerns regarding Nicole's care of them and her ability to parent them safely on her own. As highlighted by *Calder (2003)* the pre-birth assessment is a multi-agency task led by Children's Social Care in collaboration with parents which '*should help us move from a reactive, crisis-led response to a more considered, proactive, and needs led response*'. Had pre-birth assessments been undertaken it would have provided opportunities for early intervention around the care and parenting likely to be provided to Liam based both on previous history of parenting babies and testing out what would make a difference in order to protect Liam from harm.

10.20. The review highlighted that some practitioners and agencies are not yet conversant with the suite of documents that form the Gloucestershire Pre-Birth procedures and the requirements within these protocols. Given that this issue has appeared in several other recent Serious Case Reviews this would appear to be a systemic issue that should be addressed by individual agencies and scrutinised by the GCSE partnership. Consideration therefore needs to be given within individual agencies as to how well the local pre-birth procedures and unborn protocols are known, accessed and then acted on and the GCSE needs to assure themselves that the necessary improvements are made and demonstrate impact.

10.21. The GSCE has already implemented a partnership group to oversee the progress and implementation of practice improvement work for pre-birth assessment and planning. Its role is to provide challenge and to support good practice in respect of all aspects of pre-birth work in Gloucestershire. Relevant themes are shared with the GSCE for the wider partnership to agree how these can be improved upon.

Learning point two – The importance of robust and timely pre-birth assessment

This review has highlighted the importance of pre-birth planning and assessment in ensuring early understanding of possible risks as well as the level of support required by their parents as their carers to ensuring the future safety and well-being of the unborn child.

Recommendation 2

- The GCSE should consider how the partnership can support the improvement needed in practice and assure itself that all aspects of pre-birth assessment and planning meet practice expectations and demonstrating improved decision making and outcomes for babies.

Recording practice and information management

10.22. There was evidence found of poor recording practice in children's social care records where information was 'copied forward' from previous entries in the record within assessments, child protection plans and supervision records that meant that they did not reflect an accurate record of the current circumstances of the case and therefore did not support robust risk assessment and analysis. This aspect was highlighted by practitioners and family members and has also

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been a finding in recent GSCB Serious Case Reviews such as ‘James’ and in another SCR that is yet to be published.

10.23. Concerns were also found within all the component parts of this review that referral outcomes and minutes of meetings (including strategy meetings, child protection conferences and core groups) were not present on the agency record. Often this was because they were not produced by children’s social care as the responsible agency for producing these and where they were provided to agencies this was often significantly after the event had taken place. It was found that agencies, despite not having these documents (which are vital to ensure completeness and continuity of information), and in supporting informed decision making, did not routinely challenge or escalate this.

10.24. The importance of chronologies in understanding patterns and trends and the ‘bigger picture’ is well described in the Gloucestershire Neglect Toolkit. The absence of chronologies or lack of their use was identified in this case and has also been identified in several previous GSCB Serious Case Reviews. The findings around the poor recording and information management were also found within three very recent GSCB Serious Case Reviews and noted as a general practice issue and addressed through ongoing action plans which are being monitored by GCSE.

10.25. It was also found that the GP practice had not linked Emma’s records with Nicole’s as they were unaware Emma was her daughter, despite Nicole attending the same GP practice and discussing her mental health in terms of not having access to her daughter. It was suggested within the IMR analysis meeting that the relationship may have been known to the previous GPs but then not identified in the notes. However, this could not be established as the GPs are now retired. The GP IMR therefore makes a single agency recommendation to address this issue within future practice.

Learning Point three – Recording practice and information management

Record keeping was not of sufficient content or quality to know what was happening for the family, what risks were identified and the rationale for any decisions or actions to be taken. Due to the ‘carry forward’ from previous documents and missing information records were not always clear regarding the work to be undertaken and whether the desired outcomes of assessment and plans had been achieved. It is vital that agencies scrutinise themselves regarding the deficits found in record and information management.

Recommendation 3

- Individual agencies should ensure record keeping and information management systems within their organisation are robust and routinely implemented and that any deficit in the information is addressed by practitioner with appropriate management oversight.

Recommendation 4

- Where information is missing and reliant on another practitioner or agency to provide it this should be addressed by practitioners through the GCSE Escalation Policy (2019)

Recommendation 5

- The GSCE should assure themselves as to the impact on recording and information management practice drawing on the existing recommendations from three recent Serious Case Reviews.

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Resolving professional disputes and escalation

10.26. Practice appraisal confirmed findings already known within three recent Serious Case Reviews and with the Ofsted Inspection regarding the lack of a culture of respectful professional challenge.

10.27. Within the single agency IMRs reference was made that there was insufficient escalation and challenge by health professionals either in their own agency or to Children's Social Care. For instance, concerns were noted about not being able to make contact when the allocated social worker was not available. However, staff could have contacted the duty social worker, Team Manager, or Emergency Duty Team in these instances and staff participating in the review did not explain how they followed through the reporting of incidents with Children's Social Care. The GSCB Escalation Protocol supports professionally curious conversations and appropriate respectful challenge in these situations.

10.28. This review has found that there remains some evidence of a perceived 'professional hierarchy' that was referenced in the Ofsted Inspection report June 2017. There appears to be some evidence of escalating concerns regarding disagreements with decisions made at the front door or within child protection processes however, this is still underdeveloped. Effective professional challenge and resolving professional disputes therefore continues to be an area of problematic multi-agency practice that needs to be addressed and problem solved.

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Learning point four – Escalation and resolving professional disputes
More needs to be done to promote the role of escalation in partnership working together with respect and mutual understanding of others' roles and responsibilities and understanding of the limitations in practice. There should be a focus on restorative practice principles that foster and enhance partnership working and a culture where respectful professional challenge is productive and welcomed.

Recommendation 6

- The GCSE should seek assurance that the systemic findings in learning point four are being addressed and consider and implement appropriate models and problem-solving approaches to address them.

Recommendation 7

- The GCSE should seek assurance regarding the individual agency uptake and evidence of impact of its multi-agency training around resolving professional disputes and escalation.

Professional Over Optimism and professional curiosity

10.29. Practitioners throughout the case history saw Nicole as likeable and approachable and easily able to engage with staff when she was motivated to do so. Given her history of poor mental health and continued cannabis use It is commendable that workers were able to establish a relationship-based intervention with her and they all wanted her to do well. However, it can be suggested that this resulted in an overly optimistic view of her ability and motivation to change and to prioritise the needs of Emma, Logan and Liam.

10.30. As a result of this many of the aspects of care the children received that form a pattern of low-level, insidious neglect were over time seen as parental and lifestyle choices that parents are free to make, and practitioners did not want to seem judgemental of Nicole. This finding is reflective of *Brandon et al. (2014)* who described that parenting approaches accepted by practitioners reflect fears about being considered judgemental when working with families who are vulnerable, poor, socially excluded or who have made certain life-style choices. This can cause '*undue professional optimism and an acceptance of less than adequate parenting practice that results in a failure to grasp the child's lived experience and a downgrading of chronic neglect*.' This was described within the practitioner contribution as resulting in 'starting over' each time rather than looking at the 'bigger picture' and consistency in meeting the children's needs.

10.31. Fuller consideration should have been given to understanding Nicole's true parenting capability and her willingness to engage with practitioners in assessments and the plans in place in a meaningful way. There was a lack of professional curiosity within many key practice episodes with little exploration of her motivation to change, especially given that she did not hold the same concerns as professionals nor recognise her lifestyle or parenting behaviours over time as problematic. It was assessed that Nicole was complying with plans when she was willing or able but there was little evidence of engagement in interventions over time that were aimed at achieving change in her cannabis and alcohol use and improve the level of care and protection afforded to Emma, Logan and Liam over time.

Learning point five – Professional Over Optimism
This review found that there was evidence of professional over optimism that appears to be a feature of general practice particularly when working with neglect, poor mental health and substance misuse.

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Recommendation 8

The GCSE should seek assurance that the systemic findings in learning point five are being addressed and practitioners are equipped to work with them in a competent and confident manner.

Working with Substance Misuse and Maternal Mental Health

10.32. There is evidence of considerable drift and delay in achieving the milestones in both Child in Need plans and Child Protection Plans and a lack of recognition that Logan's health and development needs are not being met and that Nicole's own mental health appears to be declining. While Nicole agrees at many points over time that she will progress necessary tasks there is no evidence that this is happening. There appears to be no consideration as to whether this is evidence of feigned compliance or an indication that her parenting capacity has diminished due to her declining mental health and continued use of cannabis to 'self-medicate'.

10.33. The concerns regarding Nicole not managing her mental health through prescription medication and preferring to self-medicate with cannabis were well described in the social work assessment in June 2017. As Nicole was not recognising that her cannabis use may both affect Logan and impact on her parenting capacity, this was of concern. Although there was consideration of support through early help support it was decided a child in need plan would be more appropriate due to Nicole's previous non-engagement. This was to provide a further period of assessed needs and assurance that there would be no further negative impact on Logan's welfare. However, this assessment and referral to substance misuse services did not take place and further concerns arose throughout 2017 to 2019.

10.34. Therefore, it appears that not enough consideration was given to how Nicole's mental health combined with her cannabis use was likely to impact on her parenting capacity and whether the threshold for likelihood of significant harm was met. Had a strategy discussion been held this would have been an opportunity to triangulate the information held.

10.35. Whilst pregnant with Liam despite the long history of cannabis misuse and fluctuating mental health there was no referral to the substance misuse midwife or substance misuse service. Nicole insisted that she was no longer using cannabis, and this was taken at face value, and was not identified as an ongoing risk that needed to be addressed in the Child Protection Plan. Part of the reason for this was that the social worker understood that the midwife had undertaken an exhaled carbon monoxide detection test during Nicole's pregnancy with Liam and the test result was that of a non-smoker. When some professionals visited the family home, including unannounced visits, there was said to be no evidence of cannabis use, and there were no reports of Nicole appearing to be under the influence of cannabis.

10.36. However, it is now known that Nicole was not honest with professionals and whilst concerns were raised on several occasions in 2019 for instance, of Nicole smelling of cannabis when she arrived at Nursery to collect Logan, and of the home smelling of cannabis during a visit by the health visitor. Had the professionals working with Nicole robustly challenged her regarding her dishonesty about the extent of her continuing use of cannabis it could have been a focus of the Child Protection Plan for the children. An expectation should have been that Nicole would engage with substance misuse services and achieve abstinence. As a lone parent of a pre-school child with complex needs and caring for an infant, her cannabis use would be highly likely to undermine her parenting capability and ability to provide good enough parenting. Opportunities for hair strand testing in legal proceedings or for urine testing in pregnancy were also missed.

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10.37. Nicole was said to be exposed herself during childhood to substance misuse. Whether there was consideration of how this shaped her view regarding using cannabis while caring for children and how it might affect her parenting capability was not explored. Although Nicole had been using cannabis for many years she did not have viewed it as a possible addiction but as a recreational habit to help her relax and sleep, which may help explain her reluctance to cease using it or to seek support to do so.

Learning Point six – Substance use and maternal mental health
This review found that despite the long history of maternal substance misuse and fluctuating maternal mental health there was a lack of professional recognition and response.

Recommendation 9

- Practitioners across agencies should be equipped to robustly assess the significance of substance misuse and poor maternal mental and its impact on parenting capability and put in place an appropriate plan of support and intervention.

Provision of Safer Sleeping Advice

10.38. Safer sleeping advice is routinely provided by midwives and other health professionals at key points within pregnancy and neonatally. This documentation was given to Nicole in all three pregnancies and this is clear within maternity and health visiting records. However, given the history of cannabis use and known co-sleeping with all three children as infants, it is not clear from the records whether the increased risks of Sudden Infant Death Syndrome associated with this were discussed in core group. The discharge planning meeting identified ways to keep Liam safe from Logan's behaviours while in the home. Liam was to be placed in the Moses basket or travel cot to ensure he stayed safe when not being directly cuddled with Nicole. However, this plan did not address the issue of Nicole's history of co-sleeping and the plan should have set an expectation of total abstinence when co-sleeping with the baby at any time.

10.39. During the focussed conversation with the lead reviewer Nicole reflected that there was less emphasis on safer sleeping arrangements with each pregnancy and it was not discussed in core group. In terms of the advice given to Nicole, she did not recall whether the advice given highlighted the increased risks of co-sleeping if under the influence of substances. Therefore, where a child is subject to a child protection plan and there are concerns regarding co-sleeping it would be helpful that the advice is tailored to the child's specific circumstances and written as an expectation in the plan.

10.40. The National Child Safeguarding Practice Review Panel in October 2019 commissioned a national review to look at sudden unexpected death in infancy in families where the children are considered at risk of harm. This report from this review is due in May 2019. It would appear sensible that the GCSE considers the findings and recommendation from the national review to explore whether there is any learning relevant to the local area.

Although there is comment here on safer sleeping arrangements it should be restated that the cause of death for Liam was recorded as unascertained.

Learning point seven – Safer Sleeping Advice within routine practice
Safer sleeping arrangements are not routinely included in assessments and plans nor included as specific expectations within Child Protection Plans.

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Recommendation 10

- Safer sleeping advice should be given, repeated and reinforced by professionals in all agencies both during pregnancy and infancy and carers' understanding of the expectations on them checked at each meeting. Where there are concerns about co-sleeping in unsafe circumstances Child Protection Plans should include a specific requirement regarding safer sleeping arrangements.

Voice of the Child and Lived Experience

10.41. There were added complexities in hearing Logan and Emma's voices due to their social communication difficulties. However, there were opportunities to hear their voice throughout the period under review and understand their lived experience through observations of their environment, their interactions with others and how they behaved in certain situations and with other carers. There were also indicators of their voice within their physical presentation, age related development and their social communication needs.

10.42. There were examples of where this was done well such as by nursery and those working with Emma and Logan through the social communication pathway who recognised that they needed further support in order to communication effectively and to be able express themselves without using sensory seeking behaviours or demonstrating signs of aggression. Emma's voice was heard through school and an EHCP was applied for to meet her multiple needs which included social communication issues. Emma's lived experience was fed into the plan for permanence for her but was not always carried through once the Special Guardianship Order was granted. Logan's voice was heard in the additional support provided for him at nursey and in the play and stay sessions he attended at a special school. This resulted in the children having Education Care and Health Plans or 'MyPlans' that were updated and enhanced to meet these needs.

10.43. However, there were also examples where too much emphasis was placed on self-reporting from Nicole, rather than a wider assessment of 'a day in the life of' the children according to their age and stage of development. During the focussed conversation with the Lead Reviewer there was discussion about services being provided that were described as respite care for Nicole rather than as of benefit to Logan or Liam in providing a consistent and settled environment. This accords with a view that support provided at times appeared to focus more on identifying and addressing the views and needs of the parent rather than those of the children. There was not enough emphasis on understanding Emma and Logan's lived experience as disabled children.

10.44. The reasons for this were explored within the IMR analysis meeting and discussed at the practitioner event, where it was also noted that some practitioners may have over identified with Nicole and had a sense of '*being nurturing*' towards her with '*a feeling of pity due to her situation'*. The SCR Panel also considered how the multi-agency partnership responded to Logan and Emma as children with a disability. Whilst additional services were provided to them, there were also services that could not be accessed due to not having the 'correct' diagnosis. For example, provision of respite care for Logan, which was discussed with Nicole by his social worker, was not provided because Logan was not recognised as a Disabled Child, although he was diagnosed with an attachment disorder. However, given that there was unmet need it would have been beneficial for these services to have been provided under section 17(1), Children Act 1989.

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Learning point eight – Responding to the Voice of the child and their lived experience
The voice of the children was not always heard or responded to and while plans made and services provided may have benefitted them, this was not always designed into assessment or delivery plans that were child focussed and that considered all unmet need.

Recommendation 11

- GSCB to seek assurance regarding how the lived experience and voices of children are heard and reflected in assessments and plans and to address any gaps in practice particularly with regard to disabled children.

Understanding Thresholds, Levels of Intervention and Child Protection Processes

10.45. The threshold document, known locally as the 'Levels of Intervention' guidance, has been revised to reflect changes to policy and the local delivery structure. All agencies and practitioners involved in this review had some working knowledge and understanding of the 'GSCB - The Levels of Intervention' document and knew that it is accessed on the GSCE website.

10.46. Practitioners in all agencies were said to be aware of child protection thresholds, however there were several key practice episodes within this review where concerns were not referred via the Multi-agency Referral Form when they could and should have been. Also, they were several key practice episodes where the escalation protocol was not used as the practitioners were unsure whether the level of need and risk met the threshold for child protection. Agencies reported that they could benefit from improved understanding about the Levels of Intervention document and application of thresholds

10.47. There was also reference made within the review to some thresholds for services within health agencies being difficult to navigate and trying to access services that had diagnosis dependent thresholds. An example being was that despite Logan's presenting needs being high in terms of behaviour management and social communication he could not access certain services because he did not have the 'correct' diagnosis of Autistic Spectrum Disorder.

10.48. There are several examples in this review where the threshold for child protection processes were not correctly applied or not correctly followed at times. As highlighted within practice appraisal there were key practice episodes where strategy discussions were not held although there was reasonable cause to suspect that the child is suffering or is likely to suffer significant harm. These sometimes resulted in children's social care undertaking a single assessment without discussion with the referring agency or other involved agencies.

10.49. It was identified that this was partly because, where cases are already open and a referral is received, it is dealt with by the locality team rather than the MASH. There also appeared to be a lack of understanding that, as per Working Together 2018, '*a strategy discussion can take place following a referral or at any other time, including during the assessment process and when new information is received on an already open case*'. There were therefore several occasions where a strategy discussion or section 47 enquiries should have taken place but did not. This is a known issue being addressed by the MASH partners through a system overview improvement plan.

10.50. There are examples of strategy discussions not taking place within the practice appraisal which contributed to missed opportunities to take authoritative safeguarding action over time.

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Concerns were also identified that Nicole was asked by practitioners to take Logan to see the GP with injuries when there were concerns regarding the lack of explanation or that it did not fit their presentation. However, this is not accepted practice and each episode should have resulted in a strategy discussion before any outcome decision was made, this was an issue that was picked up in a previous GSCB SCR 'Phillip'.

10.51. Statutory child protection processes such as strategy meetings and child protection conferences were, at times, not held in compliance with statutory timescales and local guidance resulting in unnecessary drift and delay. This is also a finding within the Ofsted 2017 inspection report (as well as a recent unpublished GSCB SCR) and the subject of the Children's Services improvement plan as well as the GSCB Serious Case Review action plan. Some positive practice was noted in that, core groups were held regularly and were well attended by the multi-agency practitioner group involved with the family over time.

Learning point eleven – Inconsistent application of thresholds and child protection processes

This review found a lack of consistent:

- application of thresholds, sharing information re possible concerns or resulting referrals from practitioners to children social care.
- application of child protection thresholds and in holding strategy discussions, initiating section 47 enquiries and convening child protection conferences
- compliance with national and local safeguarding policies, procedures and guidance in relation to referrals and risk assessments across a range of concerns for children in specific circumstances

10.52. As part of the assurance received for the review the Overview Author and Panel were given access to several documents to consider the improvement work already identified and the progress made to date. In terms of the systems findings around governance and leadership much work has already been progressed and these improvements have been recognised through Ofsted monitoring visits. Though the pace of improvement remains an issue.

10.53. In addition, the Overview Author was provided with a copy of a recently commissioned report 'Child Protection System Overview, January 2020 which effectively analyses the throughput into the Gloucestershire Child Protection system, identifies pressures in the system both externally and internally, and makes recommendations to address these with clear action points and timescales. The monitoring of plans and evidence of impact will sit with the individual agencies and wider GSCE.

Recommendation 12

- The GSCE to assure itself that the practice improvements required around thresholds and child protection procedures and processes are made and demonstrating impact for children in similar circumstances.

Single Agency Practice Improvements Identified and Assurance

Within the Individual Management Review Reports agencies have identified practice improvements already made since the key practice episode of concern or further single agency improvements that are required and these are referenced in the main body of the report. Since the IMR reports were produced the following single agency assurance on their action plans has been received. If an agency update has not be provided here assurance on their action plan progress has not been provided yet or

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may not be due and the impact of their actions will be monitored through the GSCE governance processes.

Children's Social Care:

Changes already made

- Social workers are currently being trained in managing 'safe uncertainty'
- All social workers are attending 'Essentials' training which includes a module on the practice implications of over optimism
- All social work teams have a reflective team supervision session every month within which over optimism is explored/challenged.

Education Settings:

Changes already made

- A revised Safeguarding in Education offer was produced in January 2020 that includes an objective '*to ensure all children attending Early Years provision are safe from harm by ensuring that all staff are appropriately trained. To ensure that Early Years Providers are Ofsted compliant for safeguarding*'.

Gloucestershire Clinical Commissioning Group:

Changes already made

- The Neglect Toolkit was shared with the county's GP Safeguarding Leads at the annual update with the intention that this should be taken back as a training package to be rolled out within practices. The GP Locums within the county received the same training at a CCG organised event. A survey monkey audit was sent out in January 2020 to determine whether this was shared, and the results will be reported on in March 2020.

Gloucestershire Police:

Changes already made

- The Constabulary have adopted the national THRIVE+[10] model for front facing officers to use as a risk assessment tool. The expectation is that every incident created by the Police will have a THRIVE + risk assessment.
- Force wide refresher training took place in August and September 2019. Discussions with the Child Abuse Investigation Team (CAIT) Senior Leadership Team to request Decision Makers adopt the THRIVE+ in the MASH have taken place.
- In addition, the CAIT now has a very comprehensive audit process which is very closely aligned to the HMICFRS (Police inspection body) process. A significant part of the audit is dedicated to the Child's voice.
- The CAIT has also undergone significant changes and are far more proactive in delivering bespoke training. Inspectors delivered training to all control room and contact centre staff.

2gether NHS Trust:

Changes already made

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[10] The 'THRIVE' model is used to assess an appropriate initial police response based on Threat, Harm, Risk. Investigation, Vulnerability and Engagement https://glostext.gloucestershire.gov.uk/documents/s21789/appendix%202.pdf.

- This is a legacy organisation and the former parts of the trust have been asked to report all escalations to the internal safeguarding team from 01.10.19. These will be audited up to end March 2020 and to assess if further intervention with teams is necessary.
- There has been a meeting with CAMHS governance operational team to discuss the learning outcomes for the service in relation to using the escalation policy effectively. This includes senior managers, team mangers and named doctor for safeguarding children.
- There was a meeting held in February 2020 regarding the social communications pathway (GCC/CCG) and the need for oversight/ownership of the pathway to address that there are several professionals from differing services involved in the pathway but there is no one person or agency identified who oversees it. Feedback on the outcome of the meeting and further action is to be confirmed.

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Glossary

CPP (or plan)	Child Protection Plan
The Freedom Programme	The Freedom Programme is a domestic violence programme which was created by Pat Craven. https://freedomprogramme.co.uk/
Health Child Programme	A national, universal programme of five mandated visits designed to support parents to give their children the best start in life.
ICPC	Initial Child Protection Conference
Let's Talk	Cognitive Behaviour Therapy provided by https://www.talk2gether.nhs.uk/
Psychoeducational model	The psycho educational model is a humanistic approach to changing the behaviour patterns, values, interpretation of events, and life outlook of individuals who are not adjusting well to their environment.
RCPC	Review Child Protection Conference
Schedule of Growing Skills	*Schedule of Growing Skills (SGS)* is a tool for professionals to establish the developmental levels of children using *Mary Sheridan's STYCAR sequences*. The individual assessment can be used at any time with children from birth to 5 years, enabling professionals to assess them as and when appropriate and convenient.
Theraplay	Theraplay is a short-term, attachment-based intervention utilizing non-symbolic, interactional play to re-create experiences of secure attachment formation between parent and child.

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Terms of Reference (summarised)

The Serious Case Review is being undertaken using a methodology developed locally by Gloucestershire Safeguarding Children Board consisting of:

- Planning Phase
- Gathering Information and First Analysis Phase
- Quality Assurance and Initial Scrutiny Phase
- Practitioner Learning Event
- Overview Report Phase

The principles behind this methodology are contained within Working together to Safeguarding Children 2018 and are:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process
- The review will recognise the complexity of safeguarding children and seek to understand not only what happened but why individuals and organisations acted as they did.

Family Composition and Children subject to the review

The following children are considered as part of this review:

Subject Children	Relationship	Date of Birth and Age at incident
Liam	Subject	aged one month
Logan	Half-Brother	aged 3 years, 11 months
Emma	Half-Sister	aged 6 years

Scope of the review

The review covers the period from 14 December 2012 when Nicole was first known to be pregnant with Emma to the date of Liam's death on 07 June 2019 and considers relevant information prior to this period. It considers six areas of practice of concern for the three children. It was also identified that there was a common thread of Pre-birth Assessment running through each practice area. The six practice areas are as follows:

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Practice Area	Key areas of Consideration
Use of Public Law Outline	Realisation of Nicole's pregnancy with first child, Emma, until Special Guardianship Order granted 25/08/2015.
Child Protection Planning	Effectiveness of Child Protection planning for Emma, Logan and Liam.
Substance Misuse	Effectiveness of the recognising, and strategy planning, regarding substance misuse.
Partnership	The effectiveness of multi-agency working around this family across the time period.
Escalation	Use of Escalation and challenge of other agencies when the child protection plans were not considered effective.
Neglect	The effectiveness of the recognising, and strategy planning, regarding neglect.

Agency involvement

The following agencies and their practitioners were involved in the SCR process and completed Individual Management Reports (IMR) or a narrative summary of their agency involvement:

Agency	Report Provided
Education Settings	Composite IMR
Gloucestershire Clinical Commissioning Group – GP	IMR
Gloucestershire Constabulary	IMR
Gloucestershire County Council, Children's Social Care	IMR
Gloucestershire County Council, Family and Friends	Narrative Summary
Gloucestershire County Council, Legal Service	IMR
Gloucestershire County Council, Targeted Family Support	Narrative Summary
Gloucestershire County Council, Youth Support	Narrative Summary
Gloucestershire Care Services NHS Trust	IMR
Gloucestershire Hospitals NHS Foundation Trust	IMR
Gloucestershire 2gether NHS Foundation Trust	IMR

Methodology

The LSCB agreed a mixed methodology to understand professional practice contextually, to identify factors which influenced agencies and professionals in their decisions taken and, the nature and quality of work with the family. This is a blend of the traditional Serious Case Review model of a full chronology and formal agency Individual Management Review reports with systems elements brought in through the practitioner event and key lines of enquiry.

In carrying out this review the following approaches were used:

- A research and review of local and national safeguarding policies and procedures, consideration of previous GSCB Serious Case Reviews particularly those in relation to neglect, pre-birth assessment of working with vulnerable infants, Ofsted Inspection and monitoring visits, together with additional research and guidance material.
- A combined multi-agency chronology was prepared and then analysed within single agency Individual Management Review reports.

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- An Individual Management Review Analysis meeting was held with agency authors and Panel members through which further key lines of enquiry were identified. This additional information was provided within the agency final submissions.
- Practitioners attended a reflective learning event facilitated by the lead reviewer along with the IMR report Authors to consider the key practice episodes identified and to help the Panel understand why actions were taken or decisions made.

General Terms of Reference for Review

1.1	To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard children and young people and promote their welfare
1.2	To consider whether there are any specific cultural issues within one agency that may have affected decisions made by another agency
1.3	To review the effectiveness of procedures (both multi-agency and those of individual organisations) and understand what is present in our safeguarding system to enhance or hinder good practice.
1.4	To inform and improve local inter-agency practice.
1.5	To improve practice by acting on learning (developing best practice).
1.6	To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

Specific Terms of Reference for Review

1.7	To examine the quality of risk assessment and understanding of the Levels of Intervention guidance.
1.8	To consider how and when the child's views and experiences were considered and taken into account in the decision-making process.
1.9	To examine the level and quality of partnership working.
1.10	Effectiveness of the Child Protection Conference and plans.

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